A hermeneutic phenomenological study into the midwife-woman relationship.

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Abstract

Research shows that the midwife-woman relationship is important. Taking a hermeneutic phenomenological approach this study drew on the work of Heidegger and Gadamer to uncover understandings of the professional relationship between caseloading midwives and the women for whom they care. The Aotearoa New Zealand context of government funded caseloading midwifery care makes this a unique study. Data were collected through interviews with nine midwives and eight women who were recruited through purposeful sampling and snowballing. The interviews were crafted into stories which were reviewed by the participant to verify the information. Analysis considered what was said, but also pondered that which was unsaid. The method of analysis involved writing and rewriting to surface interpretive insights.

The findings revealed that both the midwife and woman came with expectations of how the relationship may play out, formed through previous experiences. The woman sought a relationship where she could trust the midwife and feel confident in her care. The 'right' midwife had relational attributes and was responsive to the woman's needs. Such relationships could be transformational for the woman. If the relationship did not feel right, some women would seek another midwife, while others would carry on hoping a connection would come. Regardless, they trusted that the midwife would enact her professional responsibilities and keep them safe.

On the other hand, the midwives demonstrated a responsibility of care by proceeding with the relationship, even if they discerned it may not be easy. They set out to gain the woman's trust by engaging in conversation that could open the way to a shared understanding. They came to attune to the woman and in doing so were able to interpret what was important to her. When the woman respected the midwife's boundaries and heeded her advice, trust was likely to develop. In some relationships, it was only after the midwife had proved herself, perhaps after the birth, that the woman was able to trust. If trust did not develop by the end of the episode of care, the midwife was reluctant to care for the woman another time. It became clear that trust underpins effective relationships. However, trust is a complex phenomenon that needs ongoing care and attention from both the midwife and the woman.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Dated: 31 October 2020

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Chapter 1 – Introduction to the study

Introduction

This thesis tells the stories of how midwives and women in Aotearoa New Zealand experience the relationship with each other when engaged in caseloading midwifery care. Each comes to the relationship with expectations and assumptions about themselves and about how the other person may behave. The midwife's understandings are shaped by professional philosophies, legal requirements, and the funding structures that she works within. The woman comes seeking a health professional who will provide her and her baby with safe care through her childbirth journey. Both bring interpersonal attributes to the relationship which have the potential to shape the building and maintenance of trust. The relationship spans the time from the first contact to 6 weeks after birth, a period of about 8-9 months. This chapter introduces the research question and outlines the background and context in which this research occurs. It describes why this research was undertaken and the way it was conducted. Finally, the structure for this thesis is laid out.

The focus of the research

The research question that guided this study was "How do caseloading midwives and the women they care for understand the professional relationship?" The methodological approach used was hermeneutic phenomenology, drawing on the writings of Martin Heidegger [1889-1976] and Hans-Georg Gadamer [1900-2002]. My objective was to consider the nature of the experience as it is as opposed to how the literature suggests it 'ought to be'. I interviewed both midwives and women who had experienced caseloading midwifery to gain the perspective from both sides of the relationship.

Justification for the study

This study is grounded on the understanding that relationships are central to health care and form the basis of a therapeutic approach. Within midwifery care, the quality of the relationship has been linked to better outcomes for the woman and her baby (Hunter, 2005; Pembroke & Pembroke, 2008; Thomas & Dixon, 2012). At the same time, midwives have reported higher levels of satisfaction within their work when they experience good relationships with the women to whom they are providing care (McAra-Couper, Gilkison, Crowther, Hunter, Hotchin & Gunn, 2014). Aotearoa New Zealand's midwifery model upholds continuity of care in which it is assumed that the midwife-woman relationship 'matters' (McLachlan, McCourt, Coxon & Forster, 2019). Research undertaken in Aotearoa New Zealand has considered what sustains

the midwifery partnership (McAra-Couper et al, 2014), what sustains the caseloading midwife (Gilkison, McAra-Couper et al, 2015; Hunter et al, 2016), what sustains midwives who practice in a hospital setting (Gilkison et al, 2017), and the principles for ending the midwife-woman relationship (MacGregor & Smythe, 2014). It is clear from these studies that getting the relationship 'right' is important for both the midwife and the woman. Additionally, research from the United Kingdom shows that women who received continuity of care experienced fewer interventions, had comparable outcomes and were "more likely to be satisfied with their care" (Sandall et al, 2016, p. 2).

When the midwife comes to know the woman and values the relationship, it is likely that what is important to the woman is also important to the midwife (Flores & Solomon, 1998). My study is focused on the relationship between the caseloading midwife and the woman for whom she cares. I explore the assumptions that the relationship 'works' and unpack how it works (or doesn't work). Specifically, I seek to increase understanding of how midwives manage the professional relationship that occurs within the context of continuity of care within Aotearoa New Zealand caseloading practice, and the women's expectations of the professional relationship.

The philosophical underpinnings

While wind itself cannot be seen, its effects are evident. So too, a relationship cannot be easily seen but its effects are apparent in how we interact with each other. How does a researcher uncover a phenomenon which is unseen and can be hard to put into words? I investigated other methodological approaches for this topic, however, it did not seem that I would get to the heart of the matter in a way that resonated with me. An approach was sought that was grounded in stories of lived experience, and that looked beyond what was said to also consider what was not said. My quest was to uncover insights from stories of lived experience. Van Manen (1997) gave an account of how hermeneutic phenomenology "tries to 'explicate' meaning that in some sense are implicit in our actions. We know things through our bodies, through our relations with others, and through interaction with things of our work" (p. xiv). Hence, this approach requires the researcher to 'read between the lines', to consider meaning that lies behind our actions.

Heidegger (1962/2008) describes a phenomenon as "that which shows itself in itself" (p. 28). He goes on to suggest that a phenomenon may "show itself as something that it is not" (p.

29). Thus, we may come to understand more about the relationship by questioning whether what first ‘appears’ is what it seems to be. It is like being a detective, uncovering what has gone before and looking to what lies ahead to increase understanding of the ‘now’. A hermeneutic phenomenological approach seeks to explore the lived experience of the participants, rather than create theory or uncover a final truth. As a midwife I have experience in reading meaning from the words and behaviour of those I care for and with whom I work. Additionally, my experience of working with women over the years has led me to appreciate the individuality of each person. Thus, such an approach felt ‘right’.

Overview of method

Eight midwives and nine women who had experienced caseloading care were recruited to discuss their experience of the midwife-woman relationship. Their interviews were audio recorded, transcribed, and then crafted into a story (Caelli, 2001; Crowther, Ironside, Spence & Smythe, 2017). The data were analysed using insights from the writings of Heidegger and Gadamer. To uncover such a hidden phenomenon requires reflexivity and sensitivity by the researcher (van Manen, 2014). As a midwife and the researcher situated within the topic, I am acutely aware of how I influence every part of the process. All participants, including myself as the researcher, are influenced by existing understandings and assumptions regarding the phenomenon being explored. Van Manen (1997) suggests that we cannot “forget or ignore what we already ‘know’” (p. 47). Instead, he states that by making these assumptions explicit we can use this knowledge to review our understandings of the phenomenon. Hence, I have used reflection throughout the research to help make my own preunderstandings apparent.

Pre-understandings

My desire to better understand the midwife-woman relationship arose from my own experiences and those of other midwives, particularly when the relationship did not go well. It was during my nursing education in the early 1980s that I first witnessed midwifery practice. Even in the hospital setting I felt there was something magical about the strength of the woman and the midwife working together towards the birth. Within my midwifery education I followed a small number of women through their pregnancy, birth and postnatal period and found that I enjoyed coming to know them as a person. As a midwife based in the delivery suite, I did not know the women I cared for. Some arrived with a detailed birth plan, anxious as to whether the midwife allocated to them would respect their wishes. As midwifery moved from the habits of care involving routines such as perineal shaving, enema, pethidine and

episiotomy, I found it exciting to work with women who wanted to share in the decision making about the care they received.

In 1988, I was invited to work alongside another midwife providing care for women who chose to birth at home. I found the women to be strong and articulate in their own homes. The experience of knowing women and caring for them in the community was inspiring and uplifting. I remember a birth where the children were excited about the forthcoming baby and then watched the birth in silent rapture. I liked the freedom of setting my own pace and knowing I would not be called away to look after other women. Of course, there was always the possibility of two women needing my care at the same time, but that was rare. Now I had time to learn what was important for the woman I was with. My previous experiences at the hospital had been nothing like that. It felt easier to provide care when I knew the woman and knew what was important to her. The women regarded having a home birth midwife as a privilege; at that time there were only three home birth midwives in our area.

I found I enjoyed working with women who worked to understand what was important to them and participated in the decision making. Some drew on scientific papers that had not been part of my previous understanding. This resulted in a steep learning curve for me as I negotiated different ways of working to those that I had experienced in the hospital. The local Homebirth Association provided education for women seeking a home birth, meaning the women were less likely to call on me unnecessarily. I remember being offered food when I attended a birth or told to go home and rest once I had checked all was well. While the pay rate was very low, I felt well supported by the Homebirth Association and a small number of General Practitioners (GP) who also supported home birth. This meant that my practice felt supported and sustainable.

The passing of the Nurses Amendment Act 1990 meant that midwives could work autonomously without the need for supervision by a medical practitioner. This was an exciting time to be a midwife. No longer would I need to call the GP 20 minutes before the birth and watch them 'catch the baby', that is, facilitate the birth of the baby, following the hours of care that I had given. No longer would I be witness to the GP who performed an episiotomy to speed up the birth in order to get back to their busy clinic. I no longer needed to find a doctor who would attend each home birth. As a profession, we were confident midwifery led care would result in better outcomes and higher rates of satisfaction for

women. We were experienced in working with obstetricians and knew that the GP sought help from the obstetrician in the same circumstances as we would. As an 'independent midwife' I was paid at the same rate as GPs received, albeit for a brief time only. Concerns over budget blowouts meant that by 1993 the payments were restructured resulting in a capped fee for both midwives and GPs. The rationale was that midwives did not have the same expenses as the GP. However, it was the midwife and not the GP who attended the long labours. This resulted in a reduction to my hourly rate.

Over the next few years approximately a third of the midwifery workforce from my local hospital moved to work as caseloading midwives in the community. Women had a choice of care provider and would interview multiple midwives looking for the 'right' one. Initially some women sought shared care between their GP and the midwife. However, changes in funding saw most GPs withdraw from providing maternity care leaving caseloading midwives as the sole option for women. I expected the strong relationships I had experienced with home birth women to continue. Implicit in this was the expectation that a woman would trust me enough to tell me what I needed to know about her life, particularly if it was something that might impact on her care.

Generally home birth women had been surrounded by people who were positive about birth. But now there were women seeking midwifery care whose families were fearful of birth. They did not want to birth at home, choosing instead to birth in the primary birth unit or at the local hospital. Some used alcohol and tobacco through their pregnancy and some had less than optimal nutrition. By the mid-1990s it seemed that women were not always well supported or knowledgeable, and sometimes not interested in their responsibilities. Anecdotally and in this study, caseloading midwives described situations where the needs of the woman have overwhelmed the midwife due to complex social problems and multiple phone calls between scheduled appointments. I remember a woman telling me her previous midwife had visited 2-3 times a day for several days to support her with her breast feeding. It seemed that some midwives were trying to provide everything that the woman needed. I did not think such care was sustainable for the midwife.

As a profession I felt midwives were not prepared for how we could respond to the unmet need we saw in the women we cared for. The addition of more requirements to the schedule of care, such as additional screening and education, alongside limited increases in payment

further eroded our equal pay status with GPs. In response to concerns about pay rates some midwives provided midwifery care within a business model, such as 20-minute appointments within a clinic setting. Ironically, midwives were enacting the behaviour for which we had criticised our medical colleagues.

While I had a midwifery partner, I was always cautious about calling her since we were already juggling our own workloads and the needs of our young families. There was a professional expectation at that time that midwives did not need days off call since our 'days off' were when the woman did not require us. Holidays were achieved by not booking any women who would be due at that time. I found that when I knew the woman and valued the relationship I wanted to be 'there' for her birth. Should anything untoward occur, I would advocate for the woman because I did not want to let her down. There were times when this created tension between me and the facility as I prioritised the woman's needs over that of the facility which sought to meet the needs of a larger group of women. Additionally, there were times when the woman's needs took precedence over mine. I remember leaving my daughter's birthday for a woman who was in labour. I remember having people over for dinner and leaving in response to being called out. This was acceptable behaviour at the time, and I would suggest that a culture of martyrdom developed in the profession. Unsurprisingly, burnout became an issue and caseloading midwives either left the profession or returned to work in the hospital setting (Calvert, 2011; Young, 2011).

Going into women's homes created situations I felt unprepared for. I cared for a woman whose family was receiving stolen property, another whose friends were using cannabis as I arrived. There was the woman who lived with family violence. The woman whose floor was rammed dirt. Another whose walls ran with water in winter and so they lived in the living area for that time. This had not been part of my experience as a hospital-based midwife. Nor as a home birth midwife. I came to realise that there were times when the woman was pretending all was well. Perhaps she did not want to let me down, or perhaps I did not want to see. My care felt insignificant in the face of so many challenges these women lived with.

Both myself and my midwifery colleagues experienced negative feedback from a small number of women and/or their families for an aspect of 'care' that we had not provided. I remember an obstetric colleague suggesting we should expect complaints as that was their reality. However, this had not been our previous experience. In the late 90's I cared for a

woman who experienced an adverse outcome. While I felt we had a good relationship, her anger and subsequent actions caused me to doubt myself. After that, I found it harder to trust the women I was caring for. By early 2000 I decided to adopt the practice of other midwives and have set days off. My partner and I took a weekend off each month. However, it felt strange to be absent from the birth having provided all the antenatal care.

I sought further changes to bring back the joy I had experienced in my work as a midwife and to understand my experiences. I started doing some university papers and found myself getting excited again, so much so that I completed a degree. I reduced my caseload and started working as a nurse in operating theatre. Eventually, after much angst, I relinquished my caseload. I found the freedom of not being on call intoxicating, but I missed the relationships I had experienced with women. I became disillusioned by the hierarchy I experienced in the operating theatre environment, so I moved to work as a well-child nurse. I was initially placed in a rural area with autonomy over my caseload. I found I enjoyed the relationships I experienced with the women, but I missed the belonging I had felt as a midwife. Where I was welcomed into women's homes as the midwife, that was not always the case as the well-child nurse.

In 2007 I moved into midwifery education. The teaching role provided the midwifery context I had missed, and I found I loved academia. I completed a Master of Education and took on the role of Head of the Midwifery School. The findings from my Master's research on midwives' experiences when working with third year midwifery students, as well as hearing the student's stories, stirred my interest in the importance of getting the professional relationship 'right' (James, 2010). I noticed some students struggled with the professional relationship; for example, they found it hard to know how much and what to share from their personal life since this was different in each relationship. Sometimes it seemed the care they gave was based on what made them feel good, rather than what was in the best interests of the woman. Learning how to manage relationships was part of becoming a midwife (Gilkison, Pairman, McAra-Couper, Kensington & James, 2015).

At the same time, I provided back-up care for some women for whom I had previously been the midwife. I found these women continued to look to me for their care and so did not form a strong relationship with my colleague who was their midwife. Consequently, my colleague did not enjoy caring for these women. When two of the women had complexities that they

had not experienced in previous births I questioned my involvement. It felt different this time as a part-time back-up midwife. While I valued the relationship, I did not enjoy it in the same way. Perhaps three of us were a crowd. I could not shake the feeling that I was just playing at being a midwife rather than really being needed. While the women expressed their gratitude for my care, this did not reassure me sufficiently. As a result, I decided not to continue working this way.

While we can list attributes and ways of interacting, this only captures part of what is important. I remember a situation from my own practice some years ago where I was asked by a colleague to provide care for a woman while the midwife had the weekend off. I was surprised to discover that the woman was someone I had cared for in an earlier pregnancy. I had thought we had a good relationship and had expected that she would return to me for any further care. The woman birthed that weekend and stated that she was delighted to have me caring for her. She shared that her friend's enthusiasm for the relationship she had experienced with the other midwife led her to seek that midwife's care. However, she was disappointed in that relationship. It seems it had not met her expectations. It is clear that this woman was looking for something in the relationship that her friend had experienced, perhaps something that neither I nor the other midwife provided. We know that when the relationship goes well, there is something special that occurs. And when it does not go well, both parties may be disappointed. Yet what makes a relationship 'right' is hard to describe. Nevertheless, that is what this study seeks to do.

Context of the study

This section will explore the historical and current events that have shaped how the midwifery profession in Aotearoa New Zealand is positioned in society and how this has influenced their philosophy, work, and relationships. We have 'rules' and ways of being that determine how we understand and interact with the world around us and each person brings these understandings to the relationship. Thus, context is important.

The medicalisation of birth

The word midwife means to be 'with woman' (Wilkins, 2000). Support and care by other women was common in traditional societies around the time of labour and birth (Hastie, 2011). However, until the early 19th century formal education was only available to men who were literate, thus perpetuating the class system and excluding women from gaining a formal

education. This meant that midwives gained knowledge through their experiences and apprenticeship from each other (Ehrenreich & English, 1973). As well, during the 19th century wealthy women were encouraged to seek medical help during their births, while midwives continued to care for poor women (Donnison, 1988). Such moves led to a narrative of control and oppression of childbirth within a patriarchal society (Ehrenreich & English, 1973).

In 1904 midwifery in Aotearoa New Zealand was regulated as a response to high maternal mortality rates as it was believed that lay midwives were "responsible for the high incidence of maternal mortality" (Abel, 1997, p.62). This included formalising midwifery education. Despite this belief, twenty years later, midwives remained responsible for approximately 65% of births, with these occurring in women's homes and small maternity units (Abel, 1997). The growth of medicine and concerns over safe birthing contributed to the medicalisation of childbirth resulting in birth moving from being a family event in the community, to a medical event in a hospital (Donley, 1998). By the 1930s most births occurred within centralised maternity services, although Māori women continued to birth at home until the 1960s, using traditional childbirth practices (Guilliland & Pairman, 2010b). In 1977, the Nurses Act required all maternity care to be under the supervision of a doctor (Guilliland & Pairman, 2010b). At that time women received fragmented care from a range of health professionals including their doctor in the community, and midwives and perhaps an obstetrician while they accessed hospital services. Postnatal care was limited. While a well-child nurse undertook home visits, her focus was on the baby.

Midwifery is an old profession, with a long history of autonomous practice caring for well women in their homes. However, for much of the 20th century, midwifery was included in nursing as "specialist nursing practice" (Pairman & Donnellan-Fernandez, 2010, p.234). This meant the practice of midwifery was dominated by the philosophy of nursing (Donley, 1998; Pairman & Donnellan-Fernandez, 2010). Yet nursing is a comparatively recent profession, traditionally based in the hospital caring for sick people, and under the supervision of a doctor (Donley, 1998). Whereas midwives valued their autonomy, it is argued that nurses were "trained to be submissive and respectful" (Donley, 1998, p.92). With two very different perspectives, it is suggested that midwives and nurses share an uneasy relationship (Donley, 1998).

Legislative changes in the 1970s, which required maternity care to be under the supervision of a doctor galvanised midwives and women into action. This resulted in the establishment of two organisations, the Homebirth Association in 1978, and Save the Midwives in 1983. These organisations sought to support normal birth, away from the control of doctors, and to reinstate the role of the midwife (Pairman & Donnellan-Fernandez, 2010). The Cartwright Inquiry from 1987-1988 into research at Auckland's National Women's Hospital increased awareness of women's health rights over the assumed authority of the medical profession (Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters, 1988). Midwives recognised the power of working together with women to achieve change at a political level. At the same time, the government regarded midwifery as cost effective due to the shorter training time for midwives than doctors and the decreased hospital costs, since women were cared for in the community (Muir, 2006). In a financially constrained environment this was an important consideration for policy makers seeking to maximise health services (Muir, 2006). The passing of the Nurses Amendment Act in 1990 meant that midwives were able to practice autonomously as a self-regulated profession, away from medical supervision. It also brought about the re-commencement of direct entry midwifery education (Abel, 1997). The Cartwright Inquiry also contributed to women/patients/consumers gaining a greater involvement in their own care, as well as in health service decision making (Tully, 1993). The partnership model developed by Guilliland and Pairman (2005) reflects this commitment from midwives to work with women and to be accountable to them.

Health service

The New Zealand Department of Health was first formed in 1900 to manage infectious diseases and ensure the health of the nation's citizens. The Social Security Act 1983 envisaged universal free health care; but this was not fully implemented due to resistance from the medical profession (Quinn, 2009). As a result, health care in Aotearoa New Zealand has been delivered via public and private services (Ashton, 2005; Quinn, 2009). However, the impact of an aging population, the increase in medical technology, and greater expectations of the public, has seen the demand on services result in escalating costs (Quinn, 2009). In response, significant changes to the structure of the health sector has occurred since 1983 to manage the increased expenditure, and to "increase accountability and efficiency" (Quinn, 2009, p.2). The introduction of managers who were not doctors, was seen as a way to achieve this. Within these reforms, equity of health provision was identified as a priority, particularly for Māori (Ashton, 2005), and so alternate models of health delivery were explored.

Free or subsidised health care is available to all citizens in Aotearoa New Zealand. Due to limitations of capacity and funding within the health services, health professionals are required to prioritise service provision (Sheridan et al, 2011). This is done by triaging the most urgent and those who meet government defined targets (Sheridan et al, 2011). Different service structures have sought to manage the health service in a way that delivers appropriate care, in a cost-effective manner (Barnett, Barnett & Kearns, 1998). The government provides funding for health services via regional District Health Boards (DHB) (Ashton, 2005). This includes hospitals, "primary care, public health services, aged care services and services provided by other non-governmental health providers, including Māori and Pacific providers" (Sheridan et al, 2011, p.3). Each DHB is managed by a board of elected representatives who are required to meet government identified objectives within a set allocation of resources (Ashton, 2005). However, reviews of the health system have identified ongoing issues with equity, particularly for Māori (Graham & Masters-Awatere, 2020; Makowharemahihi et al, 2014; Ratima & Crengle, 2013; Sheridan et al, 2011), with wide sweeping changes announced in 2020 (Health and Disability System Review, 2020).

The introduction of managerialism to the health service, sought to apply principles that were successful within a business model, to the delivery of health care (Doolin & Lawrence, 1998; Hunter, 1996). In particular, managerialism sought to control health service provision by using data collated from service delivery to predict demand and to manage resources more efficiently (Correia, 2013; Hunter, 1996). By implementing uniform processes, it also sought to protect public safety (Kuhlman, 2008) and mitigate risk of errant practice. This control has been successful in the business world, where 'McDonaldisation', has seen service provision controlled to ensure it is more efficient and predictable (Ritzer, 2012). However, the influence on health care provision is less popular since flexibility in individual care is valued by both health providers and consumers (Hunter, 1996). It is suggested that managerialism is based on "low trust relations", whereas professionals work within "high trust" relationships (Hunter, 1996, p.799). Additionally, managerialism works within a more rigid structure, whereas professionalism favours a high degree of autonomy and flexibility to meet the demands of the work (Hunter, 1996). It is claimed that this rigid structure has eroded the power of professionals, particularly doctors, who had been the predominant decision makers within the health service (Clarke, Gewirtz & McLaughlin, 2000).

Within health services, there are tensions between individual requirements and institutional processes and capacity. The rise of the 'Corporation' as a powerful entity in itself (Achbar & Abbott, 2003) is echoed in the rise of managerialism within the health service. Just as the 'Corporation' took on a persona, yet was not responsible as an ethical entity, the health service as an entity has to ration care provision to those most likely to benefit. For example, patients for elective surgery are ranked on the "level of severity or disability, the capacity to benefit from the treatment, and the ability to work and maintain independence", and this determines the timing of their surgery (Quinn, 2009, p.16). In maternity, inadequate funding for private ultrasound providers means that women must pay a part cost for scans that take place in the community. A few may meet the criteria for free scans at the hospital. Such approaches often worsen inequity and it is the health professional who must mediate with the person who is directly affected.

The return of midwifery

The Nurses Amendment Act 1990 restored autonomy to midwives. The wording of the Act reflected the midwifery philosophy that birth is not an illness and promoted a continuity of care model (Department of Health, 1990). The Minister of Health at the time, Helen Clark, called for "a change in attitude on the part of consumers and other professionals" to support the legislative change (Department of Health, 1990, p. 1). The passing of the 1990 Nurses Amendment Act resulted in a time of change for the maternity services in New Zealand (Hendry, 2003). By the mid-1990's midwives were predominantly either self-employed and based in the community, and known as Independent midwives, then Lead Maternity Carers (LMC), or were employed in the hospitals, and known as Core midwives. In 1993 the government established the Crown Health Enterprise (CHE) as a competition model for health provision. This resulted in the DHBs regarding LMC midwives as competition in the provision of midwifery care, creating a climate of distrust between providers (Muir, 2006).

Around this time general practitioners withdrew from providing maternity services, citing poor pay and difficult working relations with midwives (Exton, 2008). While in 1992 there were approximately 500 GPs providing maternity services; ten years later this number had dropped to only 79 (Johnston, 2002). By default, midwives became the "main provider of maternity services" (Pairman & Donnellan-Fernandez, 2010, p. 233). This put added pressures on the already short-staffed midwifery workforce and newly re-emerged profession, which was still developing a professional identity amidst scrutiny from the medical profession. Following the withdrawal of most GPs from maternity care, the maternity

payments were restructured, resulting in a decline in income for LMC midwives (Guilliland & Pairman, 2010b). This was the beginning of a protracted battle with the Ministry of Health to improve the contract conditions and payment that caseloading midwives received. While the midwives have seen some improvements in rates of pay, the overall goal of pay equity has not yet been reached.

An integrated maternity service

Aotearoa New Zealand has an integrated maternity service where women are cared for in the community by a Lead Maternity Carer (LMC) of her choice, who may be a caseloading midwife, general practitioner or obstetrician (Gilkison et al, 2015). The LMC is responsible for coordinating the woman's care throughout the childbearing continuum, and this includes access to hospital services if required (Ministry of Health, 2015). The caseloading midwife is based in the community and provides care during the woman's pregnancy, birth and up to six weeks after birth. Caseloading midwives determine their own workload and back up arrangements, and as a result, may decline to care for a woman. For example, if they have already booked the number of women they elect to care for in that month. A chronic shortage of midwives means there are times when the woman may have little choice of midwife, particularly in rural areas. The midwife is expected, both professionally and by contractual requirements, to provide the woman with choices about place of birth, such as at home, birth unit or in hospital, and to share her knowledge to ensure the woman makes an informed decision for her childbearing journey. Caseloading midwives are paid a fee for service within their contract with the government as a self-employed practitioner. However, unlike doctors, they are unable to 'top up' their income by seeking additional fees from the woman. All care is specified under legislation and is free to eligible women. Caseloading midwives work within a framework which specifies the terms and conditions on which payment will be made (Ministry of Health, 2007), and provides guidance for consultation with obstetric and related medical services (Ministry of Health, 2012).

Core midwives are employed within a hospital and work rostered shifts to provide care to women who require hospital level care. They have limited control over their workload, since this is determined by the facility staffing levels, the midwifery skill mix, and how many women require the hospital services during the shift. They do not work in a continuity of care model. They are bound by the hospital guidelines and policies and this limits their practice, particularly in providing care for women who require secondary services. Hence, core midwives describe situations where they are challenged by the tension between the

institutional requirements and the needs of the woman (Fergusson, Smythe & McAra-Couper, 2010). In 2015, 93.6% of women in Aotearoa New Zealand chose to receive care from a caseloading midwife over their childbearing journey (Ministry of Health, 2015). However, if the woman experiences complexity in her pregnancy or is hospitalised, she will likely also receive care from a core midwife.

Partnership

Embedded within the changes brought about by the 1990 Nurses Amendment Act was the concept of partnership with women. Guilliland and Pairman (2010a) described the relationship between the woman and the midwife as a partnership, with both contributing their expertise to the birth journey. It is expected that within the partnership, the woman and the midwife negotiate their roles in a relationship based on trust (Freeman, Timperley & Adair, 2004). Within the model the woman is at the centre of the relationship with the focus on her individualised care, rather than protocol and institution driven standardised care. The model assumes that the midwife brings professional knowledge to the relationship and will assert her professional authority if required. Such an approach also assumes that both the woman and the midwife have the desire and time to build a relationship based on trust and reciprocity.

While the Guilliland and Pairman (2010a) monograph acknowledges some women require obstetric care, it does not acknowledge that the midwifery ideology of 'birth is normal' is not shared by all woman, or all midwives. In reality the obstetric approach which assumes birth is risky and can be controlled by monitoring and intervention, influences normal birth decision making. For example, while there is no evidence to support the use of cardiotocograph (CTG) monitoring in normal birth, an 'admission CTG' is common practice for many women in our hospitals (Maude, Skinner & Foureur, 2014). Further, the partnership does not always work well. Some midwives have experienced burnout following situations where women abuse the partnership relationship, while other midwives struggle to set boundaries within their professional relationships (Calvert, 2011; Guilliland & Pairman, 2010b). Guilliland and Pairman (2010a) suggest that the concept of partnership provides an alternate understanding of professionalism. As such, the midwife-woman relationship is privileged within the midwifery ideology.

Managing emotions

Central to partnership is continuity of care. The midwife and woman come to know each other and commit to the relationship which continues for up to nine months. Through sharing of themselves they develop trust and respect for each other. This relationship supports the philosophical stance whereby the midwife seeks to achieve an optimal birth for the woman and her baby (Guilliland & Pairman, 2010a). Such relationships have been found to sustain both the woman and the midwife (McAra-Couper et al, 2014). But what if trust and respect are absent? What if the woman is not open to conversation? Relationships that are difficult may require midwives to adapt their responses to the woman and perhaps her family to meet the professional expectations of their work. This is described as 'emotion work' (Hochschild, 1979). This expectation is because the midwife as the health professional, has the greater responsibility for the quality of the relationship, due in part to the imbalance of power favouring the health professional (Cooper, 2012). It is likely that these relationships are more difficult for the midwife to sustain.

It is argued that emotion work can define "midwifery as a profession" (Lane, 2006, p. 350). It is through their skill in managing emotions that midwives are able to support "normal birth, to normalise a potentially abnormal birth, and to deliver safety and satisfaction" (Lane, 2006, p. 350). Further, Hunter (2010) claims that maintaining emotional safety is a key part of the midwife being clinically safe. These claims suggest that the relationship is an important part of care and the success of it influences how the birth plays out and perhaps even the woman's wellbeing. Thus, being able to attune to the relationship is an important skill for the midwife.

Professionalism

Midwifery practice sits within a framework of expectations, both from the profession and from society. The New Zealand College of Midwives is the professional body which provides guidance and support for midwives through philosophy and ethics statements, and practice guidelines (College of Midwives, 2018). As the regulatory body, Midwifery Council is informed by the Health and Disability Act 2000 and the Health Practitioners Competency Assurance Act 2003 (HPCAA). Under the Act, Midwifery Council ensures "midwives meet and maintain regulatory standards of education, conduct and performance so that they provide high quality healthcare" and in turn ensuring "the safety of mothers and babies" (Midwifery Council, 2018, p. 1). The College of Midwives works closely with Midwifery Council by providing several of the processes, such as Midwifery Standards Review (MSR)

and Midwifery First Year of Practice Programme (MFYP), which are required by the regulatory body to support safe midwifery practice.

Being bestowed with the title of a professional provides status for the midwife, however, in turn, this carries expectations by society about the behaviour and knowledge of the professional (Pairman & Donnellan-Fernandez, 2010). A professional is expected to demonstrate a high level of commitment to their work which is underpinned by specialised knowledge and skills (Richardson, 2001). Further, the professional is expected to demonstrate ethical practice, maintain effective communication with those they interact with, show reliability, and be committed to continuous improvement (Halldorsdottir & Karlsdottir, 2011; Higgs, Titchen & Neville, 2001; Wilkinson, Moore & Flynn, 2012). A profession is expected to be self-regulating, to monitor the standards of its members, and to be able to respond if these are not met (Wilkinson, Moore & Flynn, 2012). Such ways of behaving resonate with my understanding of midwifery, as opposed to notions of detachment and paternalism that continue to influence some understandings of being professional.

The professional relationship between the caseloading midwife and the woman she cares for can become close due to working one-on-one and having time to build a trusting relationship. So much so that the midwife has been described as a "professional friend" (Leap & Pairman, 2010, p. 339). Negotiating the boundaries in close professional relationships is fraught with difficulties, and it is evident that some practitioners struggle to navigate these (Hunter, 2006). This has contributed to a culture where caseloading midwives will work long hours, often with little support (Miller, 2002). Over time this notion of friendship has been clarified to describe the relationship as "akin to friendship" while also acknowledging "the 'time-boundedness' of the relationship and the professional focus of the midwife" (Miller & Bear, 2019, p. 319). The importance of the midwife-woman relationship provides challenges to the usual definitions of professional behaviour and boundary setting. This study seeks to increase understanding on how midwives enact professional behaviour while also maintaining a close relationship with the woman they care for.

Challenges

Unsurprisingly, the midwifery profession faces some challenges. Some midwives have experienced difficult relationships with medical colleagues due to the clash of ideologies (Youngson, Wimbrow & Stacey, 2003), and it is argued that "biomedical discourses"

continue to dominate childbirth (Davis & Walker, 2014, p. 608). High profile complaints about midwifery care (Health and Disability Commissioner (HDC), 2004; HDC, 2008) have resulted in the midwifery profession experiencing seemingly intense media interest. The increased complexity in care required by many women and their babies has put added demands on the profession. An ongoing claim of pay inequity has further undermined the profession. Additionally, there continues to be a chronic shortage of midwives and claims of bullying and burnout (Calvert & Benn, 2015; MacGregor & Smythe, 2014; Young, 2011). A recent study showed that midwives experienced high levels of stress and depression, although this was lower for caseloading midwives (Dixon et al, 2017). However, maternity data published by the Ministry of Health (MOH) demonstrates that the work undertaken by the midwifery profession results in high levels of satisfaction from women (MOH, 2011; MOH 2015), and overall, that midwifery practice is regarded as safe (MOH, 2012; Rowland, McLeod & Froese-Burns, 2012).

Midwifery gained autonomy on the basis of partnership with women. However, the ideology of partnership does not always work well with professional responsibility. Societal understandings of professional relationships regard clear boundary setting as an important safeguard for both the practitioner and the recipient of care. The midwife-woman relationship occurs over a specific period of time, within an episode of care that can sometimes be complex, and where intimacy must be balanced with professional behaviour. This research seeks to explore and challenge assumptions about how midwives enact professional relationships, and in doing so consider new ways of understanding these. It seeks to explore how women understand their relationship with the midwife who cares for them. In essence, it seeks to understand how midwives enact a professional relationship while also retaining the 'close' relationship that sustains the woman and the midwife.

Overview of the thesis

This research seeks to describe how the relationship is experienced by caseloading midwives and the women for whom they care. In chapter one I have outlined the research question and offered the background to the study. I have presented my understanding as to why phenomenology is best suited to understand this phenomenon.

Chapter two reviews the literature regarding professional relationships and the context that influences the research.

Chapter three explores the philosophical underpinnings of the research approach. The writings of Martin Heidegger and Hans-Georg Gadamer are explored to uncover philosophical notions that have helped inform my insights into the phenomenon of the professional relationship.

Chapter four describes the method undertaken in this study, including each part of the process.

Chapter five explores how the relationship is initiated. Notions of vulnerability, expectations and committing to the relationship are discussed.

Chapter six explores how participants work within boundaries. The setting of boundaries, managing boundary challenges and the notion of when 'knowing' moves towards friendship are explored.

Chapter seven considers the relationship when tensions arise. The topics explored relate to differences in expectations, managing boundary crossings and how the participants worked with tensions in the relationship.

Chapter eight considers the relationship that goes well. The topics explored relate to trust and being trustworthy, and how participants managed the relationship when it came to its closure.

The final chapter, chapter nine discusses the findings from the study and how they relate to our understanding of the professional relationship. Recommendations for practice and further research are offered.

Chapter 2 – Literature review

Introduction

This literature review presents as a "call to 'thinking'" related to the phenomenon of the midwife-woman relationship (Smythe & Spence, 2012, p. 22). Reviewing the literature provided me with an understanding of what was already known, how that knowing had come about and what gaps there may be in our knowing. The work of others provides a starting point to engage in discussion relating to the midwife-woman relationship. It seemed that much had been said already. However, reviewing the literature in hermeneutic research is more than recounting the information presented. It includes consideration of the big picture and reading between the lines. Some texts resonated with me in an 'ah ha' moment. I found myself drawn to these which often provided links to other related work.

The hermeneutic way

It is argued that engaging in a literature review too early in the research may lead to the researcher being influenced by the ideas of others (Finlay, 2011). In keeping with this approach, this chapter was written after the findings chapters. However, an inital review of the literature was undertaken to situate the study. Further it is suggested that "avoiding 'contamination' is impossible" (Fry, Scammell & Barker, 2017, p.2). It is argued that the hermeneutic literature review is not about "predicting or providing final definitions through pooling, assembling, summarising findings and critiquing the analyses" (Crowther, Smythe & Spence, 2014, e158). Rather, the literature provides a starting place for conversation allowing the researcher to reflect on the phenomenon being explored (van Manen, 1997). Heideggerian phenomenology exposes the reader to the thinking of the author and invites them to engage in their own journey of thinking (Smythe & Spence, 2012). My reading sought to uncover the ontological meaning that lay within the literature.

When I returned to undertake a full literature review I found thousands of articles relating to relationships and the notions I had already explored in the findings chapters. I focused on those articles relating to the midwife-woman relationship. As I read research already undertaken I had a moment of concern. It seemed my topic had been researched many times before and I had found little that was new. However, as I read the texts deeply and thought about their context I found differences that excited me. For example, I realised that authors talked about trust as if talking about the same concept, but I came to realise that maybe this was not so. As I played with understanding of trust I realised this is a complex

phenomenon that I did not understand well. This led me to read further texts that had arisen such as those by business leaders, health professionals and philosophers. The latter resonated with me and made apparent the many facets of trust.

Van Manen (1997) describes the literature review as a dialogue. I identified those studies that most closely resembled the context for my study and spent time reading and understanding their context. Such an approach sought to understand the shared meaning held in each of these key articles rather than undertake a systematic review of available literature. In hermeneutic research it is important the researcher is aware of their own bias (Gadamer, 2013). I recognise that my preunderstanding shapes in advance what literature will be encountered and how I may interpret the ideas presented. Yet my experience also contributes to my interpretation and provides insights into new understandings. Hermeneutic research takes the researcher on a "journey of 'thinking'… always open to what comes next" (Smythe et al, 2008, p. 1389). Being open required me to trust that understanding would come (Smythe et al, 2008). It is clear from previous studies that the midwife-woman relationship is important. Yet how does a phenomenon that cannot be seen or measured, and that is individualised for each woman and midwife, become articulated?

Reviewing the literature

In the beginning an online search using the phrase 'midwife-woman relationship' identified research that focused on the experience of midwives and women. I searched the databases of CINAHL, EBSCO host, ScienceDirect, Ovid, Psyc INFO, Medline and Google Scholar. From readings and from the voices of my participants other words arose. I initially put no time limit on my search, and this revealed some older studies that provided background understanding. However, as I became more familiar with the literature I have focused this review on studies published since 1990. This is in keeping with the change in midwifery practice in Aotearoa New Zealand following the passing of the Nurses Amendment Act when midwives gained autonomy. Table 1 shows the words used to search the databases, internet and library.

Table 1. *Words used to search the databases, internet and library***.**

Relationship and …	Midwife*, midwife-woman, health, professional, care, birth, rapport, continuity of care, caseloading midwife, community midwife, trust, vulnerability, emotion work, obstetric outcome
Birth and …	Women's expectations, continuity of care, what women want, care, with women, emotion work, midwife*, women, partnership, love, risk, trust, relationship, rapport
Midw* and …	Trust, continuity of care, vicarious trauma, stress, burnout, birth, woman

International midwifery research

Throughout, it has been important to explore any other research that was similar to my research question. A review of midwifery led continuity of care models versus other models of care for the childbearing woman, found a "higher rate of maternal satisfaction in midwife led continuity models of care", with fewer interventions, and "no adverse effects compared with other models" and with a "trend towards a cost saving effect for midwife led continuity care compared to other care models" (Sandall et al, 2016, p.2). This suggests that continuity of care is sought after by women, perhaps because it is beneficial for them, and it is promoted to women as it is cost effective. Much research into the midwife-woman relationship has been undertaken overseas, particularly in the United Kingdom, Australia, Canada and Sweden. Usually this is within settings where fragmented care is normal, and continuity of care is either not available or has limited availability. It is likely that the women and midwives who engage with a continuity of care model in these settings seek a relationship as their preference. For both it is likely this is special relationship, not only because of its uniqueness to know the other, but special also because it is different to the usual model of care that is available in that it allows women and midwives greater autonomy. Therefore, reading such research needs to consider the context the relationship occurs in since this influences who is participating in the research and what their expectations may be. Nevertheless, it is likely that many findings will be relevant to midwifery practice within a variety of settings. I have focused on those studies that specifically explore the nature of the midwife-woman relationship. I present them in relation to the key themes that emerged.

The midwife's perspective when neither are known

Different models of midwifery care mean the relationship may be one that is built over time or happens anew at each encounter. I begin by exploring the nature of the relationship when

neither party are known to each other at the beginning of an episode of care. Hally McCrea and Valerie Crute's (1991) study explored the midwife's perspective of the midwife-woman relationship in Northern Ireland. They wanted to understand the nature of the 'special relationship' which seemed to be more beneficial for women, as well as what contributed to a poor relationship. Using a qualitative approach, they undertook in-depth interviews of 16 midwives who worked within one hospital in Northern Ireland. The midwives were interviewed for 45-90 minutes while they were at work. I wonder whether being interviewed at the workplace had an effect on responses. The participants reviewed the researcher's interpretations of their data. The midwives described issues that caused them dilemmas in their everyday interactions with women and how these influenced their relationships. Using dilemma analysis, the researchers identified themes that related to understandings of the midwife's role which included concepts of recognition and autonomy, managing emotional involvement with women, and maintaining personal integrity. Dilemma analysis relates to analysis of the issues within the interview data that created dilemmas, including how those dilemmas were resolved, or not (McCrea & Crute, 1991).

The midwives described special relationships as those when they could meet the needs of the women they cared for and in turn, when the woman recognised and trusted their expertise. Being emotionally involved in the woman's care was important to the midwives and contributed to doing the "job properly" (McCrea & Crute, 1991, p. 188). If the woman did not seem to value the midwife's work, or was not receptive to her efforts, it did not feel like a 'good' relationship to the midwives. The midwives regarded honesty and trust as important to the relationship. They described situations when hospital policies required them to withhold information from the woman and they felt this was dishonest. The midwives wanted to be "allowed to 'show their feelings'" (McCrea & Crute, 1991, p. 188), in part because they wanted to be seen as people who had feelings by the women they cared for. It seems these midwives sought relationships that felt real with the women they cared for.

Despite seeking a close relationship, the midwives struggled with the concepts of "being professional and being a friend" (McCrea & Crute, 1991, p. 187). Being professional carried negative connotations for the midwives as they related this to when they managed relationships with women they found "difficult" to work with (McCrea & Crute, 1991, p. 188). This suggests they saw being professional as also being distant. The researchers explained that while students were encouraged to "care for the whole person", in practice they were expected to "develop 'professional' behaviours that included dignity, deference and distance"

(McCrea & Crute, 1991, p. 190). It seems that the culture of the unit supported being professional over being with the woman.

The researchers described midwives as having a "professional responsibility to promote the emotional and psychological well-being of their clients in addition to meeting their physical needs" (McCrea & Crute, 1991, p. 183). However, the model of care in Northern Ireland meant that the midwives did not know the woman prior to their coming together. I suggest that it is difficult to meet such needs when the woman is not known to the midwife since any knowing is likely to lack any depth of understanding. When the woman and midwife meet once labour is established, trust must be quickly established to facilitate a therapeutic relationship. I argue that while most midwives are skilled in developing trusting relationships quickly, not all women, and perhaps not all midwives are ready to engage in such relationships. This can put added stress on what is already a vulnerable time. The researchers argued that midwives needed the right environment, including organisational changes to enable the development of relationships. While this study explored the midwife-woman relationship the focus of the findings was in making changes to support the professional development and status of the midwives, albeit so they could in turn support women. I wondered what support the midwives needed so they could care for the women.

The woman's perspective when neither are known

There has also been research which focused on the woman's perspective of not knowing her midwife, and therefore not feeling 'known'. In 1996 Berg, Lundgren, Hermansson and Wahlberg explored women's experience of midwifery care during childbirth at the Alternative Birth Care centre in Sweden. The centre promoted "continuity of care, restriction of medical technology, parental responsibility and self-care" (Berg et al, 1996, p. 11). Women did not receive antenatal care from the centre but could visit before birth to familiarise themselves. Women who chose to birth at the centre were invited to participate in the study if they had experienced a normal birth, spoke Swedish and had not been cared for by the researchers. The women were interviewed two to four days after their birth and included women following their first birth to those with their fourth birth. Using a phenomenological approach, women participants were asked about their encounter with the midwife.

When the midwife demonstrated behaviour that reassured them, the women described trusting relationships. They talked of things like seeing them as an individual, being

supported on their own terms and creating a relationship where trust could grow. The women who described a negative birth experience described one or more of these behaviours being disrupted. The women stated they wanted the midwife to be "friendly and gentle", to know what was important to them, and to respect their choices (Berg et al, 1996, p. 13). When the midwife demonstrated good communication and proficient care, they were likely to experience this as a trusting relationship. Key to the relationship was the midwife's presence, both physically and emotionally. The researchers acknowledged the challenges this presents to the busy midwife, as well as the skills required to create a positive relationship when meeting the woman in labour. I suggest that such skills may not be valued by hospital managers where time to be with the woman within the busy delivery suite is challenged by tasks that must be completed amidst chronic understaffing.

The women in this study met the midwife for the first time when they were in labour. This meant they had a short time when they were particularly vulnerable, to determine if this relationship was 'right', and perhaps limited options for alternate care if it was not. The women had chosen the birth centre, perhaps because of its philosophy, and so it is likely the midwives who chose to work there, subscribed to a similar philosophy as the women. Maybe this shared philosophy gave them a mutual basis from which to start their relationship. The researchers recognised the midwives' skill in managing relationships within their practice and hoped to increase understanding of such tacit knowledge so that a "more consistent professional approach, in order to meet the women's needs" could be developed (Berg et al, 1996, p. 14). I wondered whose interests were being served by a consistent professional approach, and how that would be understood.

A personal rather than professional relationship

Within research related to the midwife-woman relationship is discussion of the personal/professional nature of the encounter. Research in England undertaken by Ruth Wilkins (1993) sought to discover what was special about the relationship between the community midwives and the women they cared for. Wilkins' (1993) interest grew from her positive relationship with the midwife when having her own children. She was aware from discussions with other mothers that the relationship was significant beyond its "professional function" (p. 47). Wilkins (1993) initially faced opposition from doctors and midwives to the research, even though the doctors were not participants, and she needed to build relationships with the midwives to enable her study to proceed. She interviewed 50 midwife-woman pairs and observed 11 midwives working with 200 women. Wilkins (1993)

acknowledged that her sample did not include some of the community midwives who she suggested may have experienced "unsatisfactory personal relationship with some of their clients" (p. 205). In the beginning some women were anxious about having their interview recorded. However, as the participants came to know her, she felt that trust and goodwill opened the way for the participants to share their stories with her.

Wilkins (1993) found that the woman's outlook strongly influenced the outcome of the relationship, with the midwife contributing to the character of the relationship. She found that a special relationship was marked by an emotional investment, with care that was woman centred. However, she argued that when the midwives took a professional stance this distanced them from the women they worked with, and from themselves as midwives. She suggested that the professional paradigm got in the way of what made the relationship special to the women. Thus, she argued that the relationship should be conceptualised as personal rather than as a professional relationship. This suggests that a professional relationship does not sit comfortably with personal elements.

Wilkins (1993) stated she was aware of a tension in how the midwives may have interpreted the data and so she decided not to link her findings to each midwife or woman. I wondered how the midwives and women might have understood the data and what their thoughts may have added to the study. Her thesis describes how the woman and the midwife experienced each other and she interprets the behaviour of the participants. Some descriptions did not make for easy reading as the participants critiqued each other's behaviour and any short comings in their relationship. I wondered if the frank descriptions were uncomfortable due to their laying open the tensions in their relationships. Biographical details of the woman labelled them by marital status, decade of age, parity and whether they were working class or middle class, although I am not sure why these mattered. The outlooks and outcomes of the relationship for each woman were summarised in a table. I wondered what was missed in the relationships that were described as "closed" or "disengaged" (Wilkins, 1993, p. 305). It seemed a simplistic view for something that is so complex, and I was left feeling that conversations between the woman and midwife that may have been difficult, had not occurred.

The midwife as a friend

Other research has been supportive of the notion of a midwife as a friend to the woman for whom she cares. Dennis Walsh's (1999) study set out to explore the woman's experience of a known midwife for labour and birth in England. At the time the maternity service was struggling to meet the government aim whereby 75% of women would be cared for by a known midwife. This led maternity service managers to question whether women wanted to know the midwife who cared for them in labour, and instead they argued that women were satisfied with traditional models of fragmented care. Within the Birth Under Midwifery Practice Scheme (BUMPS), women met up to six different midwives during their pregnancy, with an 85% likelihood of being cared for by a known midwife. Walsh stated there were only three NHS maternity services offering these partnership caseloading services. Hence, this service was unique, and it seems also under threat from managers who did not value what it offered. The qualitative study used an ethnographic approach to interview 10 women who had previously had a baby under an alternate system of care where the midwife was not known to them. The women were interviewed 8 – 12 weeks after their birth. Five of the women had a home birth leading the researcher to acknowledge the potential bias this introduced, given that women who experience a homebirth usually describe high levels of satisfaction.

The participants described their previous birth experiences in the hospital negatively. In contrast they described high trust relationships with a known midwife who cared about them. One woman shared that as a woman she was usually the carer and that she enjoyed being cared for instead. Another woman described feeling cared for when the midwife was responsive to any issues that arose, or when she advocated on the woman's behalf. The women stated they felt more relaxed and that they got to know the midwife better because of the antenatal visits occurring in their homes. This enabled their partners and children to be included which was important to them. They were reassured knowing the midwife who would be with them during their labour, and they worried if they thought she might not be there. They acknowledged the labour may not have been any different without the known midwife, but stated they felt better in themselves by knowing the midwife. As one participant said, that when giving birth "you're not in a good position to make a new relationship with anybody" (Walsh, 1999, p. 171).

The study found that the relationship influenced the women's perception and experience of the childbearing journey. When the women felt in control, they felt empowered and confident.

Walsh (1999) noted that while “expressions of gratitude and praise are relatively common in women’s evaluation of maternity care”, these women were more effusive in their gratitude. They were appreciative when they had achieved the birth they had worked toward, such as a vaginal birth following a previous caesarean section, or a homebirth.

The women described their midwife as friends and shared that they missed the midwife when the relationship ended. The midwife had been with them through their childbearing journey. This meant they felt that the relationship could never be the same with the health visitor since they did not know what the woman had been through. Walsh (1999) accepted that the professional as a friend challenges the traditional ways of working but argued that it is not just continuity of carer that supports the woman, but a close relationship. This assumes that all women and midwives seek or are able to engage in a close relationship.

The known midwife and woman in a continuity of care model

I now move on to research in which because of a continuity of care model, the woman knows her midwife and the midwife knows the woman. In 2004 Mary Sharpe explored the meaning of the midwife woman relationship in Ontario, Canada. Following legislative changes in 1994, Ontario midwives were able to practice as autonomous midwives within a continuity of care model. The midwife-woman relationship was central to the Ontario midwifery model and Sharpe wanted to know if these relationships had changed in the years since the change in practice. She described using a qualitative study with a life history approach. Participants included 43 women and 40 midwives who were not paired. Data were collected via focus groups and in-depth individual interviews. The midwife participants represented a wide range of practice situations and experience. The women were representative of the birthing population and very diverse, but women with disabilities or who required a translator did not volunteer to be part of the study.

The women reported that they valued the relationship and that a positive rapport contributed to their care. They sought midwives they could respect, who they liked being with and who provided sensitive and competent care. They enjoyed spending time with the midwife when she was focused on them and not rushed. They wanted certainty about the midwife’s availability to them including whether she took days off. Sharpe (2004) found that women drew from their experience of relationships when engaging with the midwife. For some, this meant they sought relationships that were close and experienced as empowering, while

others it was more business-like. Both women and midwives valued mutuality in the relationship but recognised this required judgement regarding what and when to share, and that there were boundaries to their relationship. Both described some relationships that felt like a friendship. However, while the women enjoyed the relationship, the midwives expressed concerns that a close relationship could interfere with their role. It seemed they were concerned that an emotional connection would interrupt their professional judgement and decision making.

The midwives enjoyed seeing the women gain confidence in their own abilities to birth and developing as mothers. They sought meaningful relationships which contributed to feeling their work was worthwhile. Sharpe (2004) claimed that when the midwives shared similar values to the woman, they found it easier to connect and to develop a relationship. In relationships where there was not a connection, the midwives reported that they were polite and ensured they acted as if they cared. Some women described noticing a difference in the midwives since the legislative change and suggested the midwives were less themselves and more bound to professional expectations. The midwifery professions in Aotearoa New Zealand and Ontario, Canada have fought to gain autonomy and to be self-regulating. It seems that becoming professional was to be valued. I wondered what was lost to midwives and women in the fight for autonomy.

Sharpe (2004) described the challenges midwives navigated providing continuity of care while also maintaining their own wellbeing. She observed that those midwives who appeared happier were supported by colleagues and family and took time off to attend to their own needs. Consequently, she recommended that midwives needed to look after themselves. Such advice resonated with my own experience of learning to balance the expectations of the midwifery relationship with my own needs and was echoed in the study on burnout by Carolyn Young (2011). I wondered, who cares for the carers? Are they solely responsible for their own wellbeing or does the maternity system need to be structured to support their ways of working?

Emotion work in the relationship

Relationships play out within an emotional context. Billie Hunter's 2006 study explored the emotion work experiences of midwives and the women they cared for. Her participants were 19 community-based midwives located in South Wales. She used a qualitative study with an

ethnographic approach. Participants were observed during their visits with women they cared for. The midwives also participated in interviews and in three focus groups. Hunter (2006) observed that community-based midwives spent more time with the women they cared for than with their colleagues. Hence, she was not surprised to find that the midwives evaluated their work satisfaction in terms of feedback from their clients rather than from their colleagues. These findings are echoed in the 2014 research by Garrett of midwives who worked outside the NHS. I wondered whether midwives who are loyal to the maternity service rather than the women, are less trouble for the maternity service, since they are more likely to put the needs of the service ahead of the needs of the women, although these should be the same.

The midwives reported enjoying their relationships with women. However, Hunter (2006) observed the midwives adapting their behaviour to fit in with the different women. Getting to know the woman enabled the midwife to determine how best she could provide care that met the woman's needs and to determine the "give and take" in their relationship (Hunter, 2006, p. 315). If the woman accepted the midwife's care and advice, the midwife felt "valued and appreciated by the woman" (Hunter, 2006, p. 315). Such relationships sustained the midwife professionally and personally. I wondered if personally negotiated boundaries provide both the woman and the midwife with confidence to engage in a deeper relationship.

Some women challenged the boundaries set by the midwife. Some had unrealistic expectations or were felt to be overly dependent, while other women rejected the support offered. Hunter (2006) observed that the midwives were more responsive to requests from the women for emotional support than to those of practical support. The midwives worked hard to build rapport with women. However, when their efforts were not reciprocated, they felt frustrated and unable to do "real midwifery" work (p. 317). This suggests that the midwives expected midwifery work to include the relationship.

Hunter (2006) proposed a model to describe reciprocity in the midwife woman relationship. These were described as:

- a balanced exchange with balance in the give and take and where the midwife felt validated
- the rejected exchange where the woman was unresponsive or even hostile to the midwife and her advice

- reversed exchanges where the woman attempts to support the midwife, however such support is considered inappropriate by the midwife
- unsustainable exchange where the woman has expectations of the midwife that are considered unrealistic by the midwife.

Hunter (2006) suggested that the lack of reciprocity in these relationships caused the midwife to engage in emotion work to try and achieve a balanced relationship. It would be interesting to understand the woman's perspective in such situations. Perhaps she sought more support than the midwife was able to give. Perhaps she was not confident in the midwife's care. Or maybe she lacked other support from family and friends.

Central components of the relationship

The nature of the midwife-woman relationship has been brought to question. Lundgren and Berg (2007) undertook a secondary analysis that sought to "delineate the central components of the midwife woman relationship during childbearing, in normal as well as high-risk situations" (p. 220). Using eight Swedish qualitative studies, including one described previously, they reviewed the data using a phenomenological approach. There were 96 participants over the eight studies. Data had been collected via diaries in one study, and through interviews for the remaining studies. They identified six pairs of concepts which described the central components of the relationship, with one being from the woman's perspective and the other from the midwife. These are described in Table 2.

Table 2. *Central components of the midwife-woman relationship.*

Woman	Midwife
surrendering to herself, or in a complex birth, to the health professionals	being available to respond to the woman
trusting herself and her body	promoting a trusting relationship
participation in her birth, evidenced by feeling listened to and supported	engaged in dialogue and being open to sharing (mutuality)
feeling lonely in response to the unknown and responsibility of birthing	responds with support and her presence (confirmation)
feeling different to what was normal	supports the woman's individuality (uniqueness)
the pregnancy and birth enabled the creation of meaning	"support the woman's sense of meaningfulness" (p. 224) including promoting hope and a "focus on normalcy" (p. 225).

(Lundgren & Berg, 2007)

This approach requires the midwife to be alert to what is important to the woman and responsive to her concerns, always balancing normal and medical views. In doing so the researchers suggest the woman is more likely to trust the midwife, and perhaps more importantly herself and her ability to birth. They posit the midwife has a responsibility to meet the needs of the woman but caution that to do so, the midwife must be supported also. Their findings make explicit the considerable presence and emotional availability required by the midwife. I wondered whether our focus on technology has been at the expense of the relationship.

Midwives who step outside of the system to 'be with'

Midwifery models of care as dictated by health services have a strong influence on the possibilities of how the midwife-woman relationship can grow. Some midwives have chosen to practice in an independent manner to enable them to build the kind of relationship they believe is important. In 2014 Rosemary Garratt's study explored the lived experience of midwives in the United Kingdom (UK) who practiced independently of the National Health Service (NHS). The midwives were based in the community and paid directly by the women they cared for. They cared for women seeking a home birth or who had complex obstetric and psycho-social needs. Some women had previous negative experience in the NHS and so sought additional support for this birth. Garratt (2014) suggested their way of working was viewed as "the 'Gold Standard' of midwifery practice" by many, as they offered individualised care throughout the pregnancy, birth and to six weeks after birth (p. 12). Garratt (2014) aimed to understand the midwives' motivations for working this way and their perceptions of the relationships with the women they cared for. Using hermeneutic phenomenology, she undertook in-depth interviews with 20 independent midwives from all over the UK. The data were analysed using an adapted version of the biographical narrative interpretive method.

The midwives shared that their inability to work 'with woman' in the NHS had led them to independent practice. They enjoyed the closeness in the relationship and getting to know the woman and her family. They took a small caseload to ensure they could provide the quality of service that was important to them, such as time to be with the woman. Garratt (2014) referred to this as "slow midwifery" as opposed to the "fast midwifery" that occurred in the hospital setting (p. 320). The midwives described their relationship with the women as pivotal to understanding of the woman's needs, and that helping her achieve her birth goals contributed to their job satisfaction. I suggest that the midwife who knew the woman

presented the best option for the woman to achieve her birth goals, or to understand if these were not achieved, because of their relationship.

The midwives reported challenges in their role. Independent practice did not offer the financial security the NHS had, and they struggled with work-life balance and being on call. In working to meet the woman's needs and respecting her rights, the midwives felt vulnerable to criticism from their colleagues, particularly when they transferred a woman to hospital for obstetric care. As a result, there were times when they struggled to support the woman's preferences due to the institution's protocols and guidelines, which did not consider the woman's specific situation or her wishes. Additionally, they were aware of situations where midwives were bullied or disciplined for advocating for women.

The midwives worked without professional indemnity insurance. They were aware of the vulnerability and risk of independent practice but argued the importance of a trusting relationship to help the woman to feel safe and in control. Within the relationship the midwives wanted to know that the woman would listen to her advice, while also acknowledging the woman's right to not take that advice. While they needed to trust the woman, they were mindful that she could complain to their registration body if she was unhappy with her care, and that this could trigger an investigation which carried unforeseen consequences for the midwife. It seems to me that these midwives would be skilled in understanding whether the woman could be trusted to own her decisions in the event of an adverse outcome.

Garratt (2014) reported that despite a desire by midwives to move towards more relational models of midwifery care, the maternity service in the UK had reverted to fragmented ways of working. This led her to suggest that she was recording the experiences of a disappearing group of practitioners who had embraced professional autonomy and responsibility, but in doing so took personal and professional risks, within a context that did not support them. I wondered if the perception of 'gold standard' meant that such high quality ways of working were not regarded as sustainable. Many of the stories resonated with my experience of midwifery in Aotearoa New Zealand. I wondered what effect being paid directly by the woman had on the relationship. I felt grateful that in Aotearoa New Zealand caseloading midwifery is integrated into our maternity service and pondered why relational ways of

working had not been implemented in the UK. I wondered whether technology is valued over relational ways of working.

Trust in the relationship

Many of the studies discussed thus far have talked about trust. Marie Lewis (2015) specifically explored the concept of trust within the midwife-woman relationship in Wales. The midwives worked in a caseloading model in the only NHS maternity service that offered complete midwife led care. She sought to gain further understanding of the women's experience of trust when they knew the midwife. Taking a Heideggerian phenomenological approach she undertook longitudinal interviews of nine mothers. Analysis was conducted using NVivo 9 software and applying a Hybrid model for concept analysis. This suggests she did not dwell with the data in a Heideggerian manner. She noted that the hybrid model altered the "interpretation of the data from being unique to having aspects of shared identity in the form of the theoretical concept" (Lewis, 2015, p. 187), and argued that this was necessary to "establish meaning of the language used to describe trust within this context" (Lewis, 2015, p. 187). Thus, what started as a Heideggerian phenomenological approach seems to have moved from the ontological lived experience to become more epistemological, offering theoretical concepts distanced from the lived experience.

Lewis (2015) described building blocks that contributed to evolved trust. These included concepts of initial trust based on the assumed competence of the midwife and a need to feel safe. A reciprocal and empathetic relationship built on the initial trust to reach evolved trust. Lewis (2015) described evolved trust occurring when the women described a "positive experience of developing a relationship with the midwife that assisted them in achieving their goal – a safe birth" (p. 149). For the women, feeling safe included feeling cared for, being in control of decisions and having their agency supported. She acknowledged that "feeling safe was not necessarily the same as being safe from a clinical perspective" (Lewis, 2015, p. 166). Lewis (2015) proposed that the woman needed to feel safe before she could build trust with the midwife. If the midwife did not meet the woman's need to feel safe, was not empathetic or the relationship was not reciprocal, trust did not evolve. Therefore, she argued that the midwife should establish a connection with the woman to support the development of trust.

The women identified first impressions helped them to determine whether the midwife would be a good fit to them. To achieve this, Lewis (2015) suggested that the midwife's personal characteristics were important and that maternity services needed to allow for women and midwives to know each other. The women described assessing the midwife during their antenatal care to confirm that they could connect with her and in turn, that she could be trusted for their birth. Women in the study described reduced trust in the hospital midwives due to their previous experiences. This meant they were reluctant to engage with hospital services. A key finding from the study was that it was important to the women that the midwife trusted them also. Additionally, the study found that when one midwife was trusted this could be transferred to another midwife. However, taking this analysis to a theoretical level is likely to have hidden the complex nuances of the lived experience.

Being with woman (when this is not usual)

The studies described thus far have been from the northern hemisphere. This next study is Australian. Bradfield, Hauck, Kelly and Duggan (2019) explored Western Australian midwives' experiences of being 'with woman' during labour and birth. Using a descriptive phenomenological approach informed by Husserlian philosophy they gathered data via interviews. Being with woman is a central statement in the Australian College of Midwives philosophy, however continuity of care is not embedded in the Australian maternity service. This meant that the researchers wanted to understand how being 'with woman' was understood within the different models of care experienced in Australia. A total of 31 midwives who worked across three different models of care were interviewed: 11 midwives employed at four private obstetric hospitals in Perth where the woman knew the obstetrician but did not know the midwife; 10 midwives who worked in a known midwife model of care; and 10 midwives who worked in public hospitals and did not know the woman.

All the participants described the importance of making a connection with the woman and establishing a rapport. The midwives who did not know the woman prior to providing labour care worked hard to build a relationship quickly. They recognised the woman's vulnerability when she arrived in labour and had established ways to connect with her including listening to what she wanted and by being present, both physically and emotionally. The midwives also built a relationship with the woman's support person. If the woman had chosen an obstetrician, they took care to "acknowledge and respect the pre-existing relationship" (Bradfield, Kelly, Hauck & Duggan, 2019, p. 161). The midwives recognised the financial investment the woman had made by employing a private obstetrician however, they were

frustrated if this meant their skills were not recognised by the women. For example, if the woman did not seem to value their advice they would hold back in the relationship. The midwives who had developed a trusting relationship with the obstetrician were able to advocate with greater success for what the woman wanted. However, they described their frustration when they felt the obstetrician's preference was more important than the woman's choice. Reading the participants' stories reminded me of midwifery practice in New Zealand some 30 years ago when the midwifery and medical professions struggled for their place. I wondered whether the midwife who did not have an established relationship with the woman found it easier to support the long-term relationship she had with the facility and the obstetrician. Or maybe the obstetricians chose to work with midwives who would uphold their opinions and not challenge them.

The midwives working in the known midwife model worked in group practices of 4-6 midwives. The midwifery led service was publicly funded with the midwives providing care to women from 16 weeks gestation, through labour and birth and up to two weeks after birth. The women met all the midwives in the practice during their antenatal care, with a commitment that two would be present for her birth. While the women did not know which two midwives would be present, this gave her some certainty that it would be someone she was familiar with. To be eligible for the service women needed to live within a 50km radius and self-referred to the service. This suggests that the women sought out the service and valued midwifery led care. The midwives had previously worked in systems where they did not know the labouring woman and believed it was easier to provide care in the known midwife model that the woman wanted, because of their established relationship. This study sought to change how midwifery care is delivered in Western Australia and echoes a 2015 study (Davison, Hauck, Bayes, Kuliukas & Wood) that had similar findings. I wondered what evidence decision makers require to implement such a model of care.

Research in Aotearoa New Zealand

Aotearoa New Zealand is described as the "only country in the world to have continuity of care as a core tenet of its maternity system" (Grigg et al, 2017, p. 9). The concept of continuity of care assumes the midwife is in a relationship with the woman. Therefore, the studies in this section relate to practice where the midwife and woman are known to each other and have had time to build a relationship. Some research undertaken in Aotearoa New Zealand focused on the model of care and this inherently included aspects of the midwife woman relationship (Fleming, 1998; Pairman, 1998). More recently research has included

the relationship while focusing on: sustainability of practice (Gilkison et al, 2015; Hunter et al, 2016; McAra-Couper et al, 2014); the principles for ending the relationship (MacGregor & Smythe, 2014); and the impact of burnout (Calvert & Benn, 2015; Young, 2011). This study explores the midwife-woman relationship within a setting where the midwife and woman know each other and have had time to build a trusting relationship (or not).

Looking for a framework

I identified two researchers who developed frameworks to understand the midwife-woman relationship in Aotearoa New Zealand. In 1995 Guilliland and Pairman's (2010a) monograph described the relationship between the woman and midwife as a partnership. The model was developed through a process of collaboration by the authors and evolved through practice experience. Their philosophical underpinnings were that pregnancy and birth are normal life events and so reflect midwifery's primary role, that midwifery care is provided by one midwife (and her backup midwife), and that care is women centred. They argued that a successful partnership was dependent on the integration of concepts of "individual negotiation, equality, shared responsibility and empowerment, and informed choice and consent" (Guilliland & Pairman, 2010a, p. 41). They suggested that the woman and the midwife brought their own knowledge and expertise to the relationship. The relationships they described were reciprocal and trusting and assumed that both wished to engage in a relationship.

The notion of partnership was challenged by Joan Skinner (1999). She argued that the partnership model did not recognise the power imbalance between the woman and the midwife particularly relating to different knowledge bases, nor could it respond appropriately to complex social relationships that were present between midwives and the women they cared for. She recognised that not all women wanted a partnership. Instead, she suggested that concepts of respect, trust and caring should be incorporated to ensure that complexities of culture and different expectations can be addressed. Additionally, she raised the concern that the woman could leave the partnership at any time, as she had observed in the event of an adverse outcome. In this situation the woman may reject the decisions made within the relationship leaving the midwife "accountable for all negative consequences" (Skinner, 1999, p. 15).

In 2010 Guilliland and Pairman published a second edition of their monograph that revisited the midwifery partnership model. They recognised that continuity of care had not extended

into hospital settings as they had anticipated. Instead, caseloading midwives had continued to provide some continuity of care for women who required hospital services. They described the midwifery partnership as a “relationship between a woman and her midwife” (Guilliland & Pairman, 2010a, p. 59). They reiterated their belief in normal birth and acknowledged the tension for midwives in balancing their roles as the guardian of normal birth while also ensuring the need to assess and identify when complications arose. They reaffirmed their understanding that the partnership incorporated the principles of equality, mutual respect, reciprocity, and trust. However, they acknowledged that the quality of the relationship was determined by the partners involved. They cautioned midwives that “having a positive, reciprocal, and equal relationship is of no use if the midwife abrogates her professional responsibilities” (Guilliland & Pairman, 2010a, p. 69). I wondered whether midwives had privileged the relationship over midwifery decision making.

In 1998 Valerie Fleming’s research developed a conceptual model of midwifery practice. She argued that the renaissance of midwifery meant that the profession needed to consider the “theoretical underpinnings of midwifery practice and to be able to define what is distinctive about that practice” (Fleming, 1998, p. 137). Taking a qualitative approach using grounded theory, she described having more of a conversation than an interview with 137 midwives and 109 women from Aotearoa New Zealand and 113 midwives and 110 women from Scotland, all of whom practiced in either community or hospital settings. She asked participants what midwifery practice meant for them. Data were analysed using NUDIST qualitative analysis package. She identified six core categories which she described as:

- the midwife being there for the woman (attending) and being with as described by the woman (presencing)
- the midwife doing something for the woman (supplementing) and enhancing the woman’s ability and experience (complementing)
- women looked back on their experiences or those of their family and friends to choose their midwife (reflection) and midwives reflected on their own practice (reflexivity).

Threaded throughout was the concept of reciprocity. Fleming (1998) argued that reciprocity was the “essence of all successful midwife-client relationships” (p. 142). Her model included contextual factors relating to personal and professional attributes and acknowledged the constantly evolving nature of the relationship. She claimed that the model went some way to address criticism by Ginzberg (1989, as cited in Fleming, 1998, p. 142) that midwifery took an “undeveloped and less scientific approach to the same problems that obstetrics” sought

to solve. Fleming suggested that further research was required so that midwives could "articulate the nature of their practice and differentiate it from that of other disciplines" (p. 143). While she sought to understand women's ways of knowing she urged that her model should be subjected to empirical testing to validate it. Such an approach privileges scientific ways of knowing. I suggest that while evidence-based care underpins midwifery practice, midwifery knowledge also embraces women's ways of knowing that include practice wisdom, relational ways of working and storytelling.

The known midwife and woman in an Aotearoa New Zealand continuity of care model

In 1998 Sally Pairman undertook research to explore the nature of the midwife-woman relationship. Midwifery in Aotearoa New Zealand had undergone significant changes with the move to autonomous practice in 1990. The research took a qualitative approach underpinned by a feminist philosophy. The study sought participants who were representative of the model of care that had been implemented. That is, they worked in 'independent' midwifery practice providing continuity of care and were engaged in the midwife-woman relationship. The participants were six midwives and six women they had cared for, and who had birthed between six weeks and four months previously. The participants were interviewed individually and then participated in two focus groups. The participants engaged in analysis of the data and the identification of themes. The study did not include any participants who were working in "a 'shared care' model with another practitioner" (Pairman, 1998, p. 5). This stance assumed that working in a shared care model undermined the independence of the midwife. This was a philosophical position and in part based on research by Guilliland (1998, as cited in Pairman, 1998) suggesting that well women who received shared care from a midwife and a doctor experienced poorer outcomes than those who received midwifery only care. At the time midwifery in Aotearoa New Zealand was establishing itself as a distinct profession and this stance reflects that.

The women participants were described as active participants in their care, and this included sharing responsibility for their decisions. The midwives and women believed they contributed to the relationship equally. They described a close relationship with the women saying they looked forward to the midwife's visit. They liked that the midwife took an interest in them as a person, rather than just as a pregnant woman. This helped them to feel listened to and "special'' (Pairman, 1998, p. 7). The midwives described taking time to know the woman, and this often included her family. It is likely that the participants in this study were motivated and engaged in the relationship and in their birth experience. I wondered how the

relationship would be sustained if the woman was less willing to participate in her care, or to take responsibility for her decisions.

The women participants suggested the relationship felt like a friendship, whereas the midwife participants described it as a partnership. The concept of partnership reflected the philosophy that underpinned midwifery practice in Aotearoa New Zealand. Pairman (1998) explored the literature relating to the notion of friendship and found that the relationship bore similarities due to the intensity of the relationship and the bond shared between the woman and midwife. However, the literature was clear that the "notion of friendship was an inappropriate description of health professional relationships" (p. 8) due to the professional responsibilities of the health practitioner. Thus, Pairman (1998) suggested that the term "professional friend captured the intensity and intimacy of the midwife/woman relationship" (p. 10). The women and the midwives agreed that the relationship changed and usually ended at the end of the episode of care. One midwife shared that it was not realistic for her to continue a relationship with all the women she had cared for. I wondered what shape the relationship would take once the reason for coming together is gone, that is, the episode of care has ended.

The known midwife as 'support'

Other research continued to seek the difference it made having a continuity of care model of practice. Howarth, Swain and Treharne's (2011) research explored the experience of giving birth for first time New Zealand mothers. They argued that birth satisfaction was important for every woman and that personal and caring support contributed to this. Therefore, they sought to understand the woman's experience of support leading up to and including their birth considering the woman's relationship with her midwife, and with her partner, family, and friends. They advertised in the local community newspaper asking for women who had birthed a healthy baby in the previous four months, were aged between 18 and 42 years, had been cared for by a midwife and lived with the father of the baby. All participants were able to speak and read English. Some participants responded to the advertisement, while others were recruited through snowballing. Three of the women had homebirths and seven birthed in hospital. Taking a qualitative approach, they interviewed 10 first time mothers using semi-structured interviews that were face to face. Data were analysed using thematic analysis informed by Interpretative Phenomenological Analysis. Each woman's interview was summarised into a birth story and sent to the woman to review.

The women shared that finding the right midwife was important to them although this had been impacted by a shortage of midwives. The women sought a "close and personal" relationship with their midwife (p. 8). This enabled them to trust the midwife which brought with it a sense of security for them. The women wanted to feel cared for as an individual, and for the midwife to advocate for them if that became necessary. The researchers found that the "midwives who were most successful guided without dictating and encouraged their clients to be proactive in managing their own labour and birth processes" (p. 10). This echoes findings from international research (Lundgren & Berg, 2007).

The study also considered the support the woman experienced from her partner, as well as the communication between midwives and doctors. All the women expected their partners to support them during labour and birth and identified a lack of resources to support their partners to transition to be a father. They reported feeling anxious when their partners struggled with witnessing their labour, and when they were then unable to stay after the birth due to hospital policies. The women described multiple ways their family and friends supported them, as well as the support and care from the midwife. I wondered how women managed when they lacked this wider support network and whether the woman looked to the midwife in the absence of supportive family and friends.

The cost of burnout

Amidst the joy of autonomous practice, a dark side surfaced, of midwives who were exhausted from caring. Research by Carolyn Young in 2011 explored the experience of burnout amidst caseloading midwives. Taking a hermeneutic phenomenological approach, she interviewed 12 midwives who self-identified they had burnout while giving care as a caseloading midwife, as well as four partners of midwives, about their experience. Participants described their struggles to maintain boundaries that protected themselves, a lack of support from colleagues particularly during long labours, and experiences of bullying within the profession. They were challenged when caring for women who abused the relationship, who did not want to make decisions or whose lives were compromised by drugs and alcohol. In response the midwives retreated into themselves, unable to voice their concerns amidst feelings of shame and the need to be seen to be coping. Within burnout the midwives were unable to see a possible way out. They looked to management and the professional body for solutions, but none were forthcoming. They felt alone and exhausted and drew back from engaging with the women they cared for. Despite their exhaustion some remained working out of loyalty for the women. Some recognised the potential for poor

decision making in such situations. For some the only way out was to cease practice, yet with the responsibility of a caseload that was not easily achieved. It is clear that these midwives' experiences, while embracing the ideology of partnership, found it increasingly exhausting to offer such a demanding level of commitment.

In 2011 Irene Calvert also completed her study on the effects of a traumatic practice event on the midwife. Using a narrative research approach Calvert (2011) recruited midwives who self-identified they had a traumatic experience. She interviewed 16 midwives over two sessions about their experience. She argued that midwives' ways of working in partnership with the woman challenged the beliefs of medicine, and that along with their autonomy, this made them vulnerable. They were more likely to be blamed and have their competence questioned in the event of an adverse outcome. Her findings supported other studies which showed that it was the social structures and response that created physiological and psychological effects, rather than the trauma itself. It was this breakdown in trust that exacerbated the trauma, changing the meaning of the event. The sequelae of the traumatic experience led to some midwives experiencing chronic illness, while others changed how they practiced or left practice altogether. This resonated with my experience of the adverse outcome I had been part of. While I received great support from my colleagues, the woman's subsequent anger and behaviour towards me felt personal. I did not know where she would appear next as she sought to disrupt my practice. I recognised her pain but did not know how to respond to her.

Sustainable practice

While there was much to celebrate in the growth of the continuity of care model within New Zealand midwifery, there were also growing concerns about its sustainability. Research by McAra-Couper et al (2014) explored how caseloading midwives in Aotearoa New Zealand had sustained themselves in practice. They argued that while continuity of care has been shown to be beneficial for women and midwives, it was also beneficial for society due to the economic and social benefits. However, they wanted to understand how midwives were sustained within a continuity of care model. Using a qualitative descriptive approach, they interviewed 11 midwives from rural and urban locations across Aotearoa New Zealand, who had 8 – 20 years of experience as a caseloading midwife. They used semi structured and open-ended questions to explore participants' experience of what sustained them in their practice. If participants requested, they were able to review their transcripts. The data were analysed using thematic and content analysis.

The midwives shared that support from practice partners who were "philosophically aligned" as well as from family and friends was key to sustainable practice (p. 31). The midwives described the joy they experienced in the reciprocal relationships they experienced with the women they cared for. This echoes Fleming's (1994) research which found that reciprocity was important for a successful relationship. Participants felt that midwifery was "more than a job" (McAra-Couper et al, 2014, p. 31). Instead, being a midwife defined who they were and influenced how they experienced life. The midwives described negotiating clear boundaries with the woman which kept both themselves and the woman safe. They reported being able to say 'no' where appropriate and believed they were not indispensable to the women they cared for.

Participants talked about how much they enjoyed being part of women's lives at this special time. They enjoyed supporting women to achieve their birth goals. One participant had cared for several women in one family and felt special when her care of the family was acknowledged by an older family member. The researchers suggested that sustainable midwifery practice was associated with midwives being able to make a difference and working for the "greater good" (McAra-Couper et al, 2014, p. 32). It seems that positive relationships alongside clear boundaries and work-life balance, as well as being altruistic sustains midwives in their work.

Reading as thinking

Alongside reading the midwifery literature, I was drawn to other more philosophical sources to open my thinking. While such reading was not directly related to midwifery and/or birthing women, the notions within the texts resonated with me. Frederik Svenaeus (2011) discussed illness as unhomelike being-in-the-world. He described an "otherness … understood here as a foreignness" (p. 333). There is certainly an otherness about pregnancy whereby neither the body nor the self is as familiar as it once was. However, I do not regard pregnancy as an illness or the woman as unwell, although she may be. Yet if I insert the word 'pregnancy' instead of 'illness' there is a congruency. For example, there are times when the "body in (pregnancy) is gradually objectified" (p. 335), or when pregnancy "breaks in on us… necessitating a re-envisioning of the future" (p. 333). While I was drawn to some parallels, I was cautious about where this might lead me.

I read Brené Brown's (2010; 2017) work on vulnerability and cultivating resilience. Core to her message is the concept of accepting ourselves for who we are. She describes our need to belong and to connect with those around us. In a world that is so connected it is ironic that so many feel lonely. I found myself drawn to her messages about humanising our relationships with others through relational and personal attributes such as reliability and generosity. I wondered whether the busyness of our lives meant that we have forgotten about the importance of relationships.

I was drawn to work by Martin Buber describing the I-Thou relationship. This echoed my experiences of some of the relationships I had with women I had cared for. Sometimes they occurred with a woman who initially did not seem to have much in common with me. Buber describes such relationships as one of "openness, directness, mutuality and presence" (Friedman, 2002, p. xiii). It seems our readiness to engage in a relationship determines how it could develop. Perhaps it is in that moment of both being present and with the shared goal of her birth, that the midwife and woman can connect.

I was challenged by Louis Profeta's (2016) suggestion to health professionals that they need to remember "it's just a job". His audience of health professionals argued that the concepts of passion and sacrifice were a prerequisite for them to provide good care. In turn he suggested that validation needed to come from within, and that the consequence of seeking it from others was burnout. Certainly, I remembered times when I put the women I cared for ahead of my and my family's needs. Yet anecdotally, colleagues have reported that putting their family first has resulted in women seeking care elsewhere. I wondered if there are times when midwives and women have different expectations of the relationship and how realistic these are.

Arlie Hochschild's (2012) study of emotion work resonated with me. She researched flight attendants who were expected to be happy at work, and to hide any fatigue or irritation they may experience. When their workload was less demanding, and the clientele more select, they found it easier to feel genuinely happy. However, as the price of airfares dropped and schedules became busier, the clientele also became less exclusive, and it seemed, more demanding. This meant the flight attendants had to work harder to create the elation they were expected to project. I could see some parallels between the experiences of the flight attendants and midwives. I certainly found it more enjoyable to work with women who were

engaged and took responsibility for their decisions. It was easier to be kind when I felt the work I did was recognised and valued by the woman, and that I was remunerated fairly. It seems that the business of caring is poorly understood by those who hold the purse strings.

The writing of Robert Solomon (Flores & Solomon, 1998; Solomon & Flores, 2001) resonated with me. As a professor of philosophy his writing captured the nuances of trust in a way that helped me to see the myriad of ways that trust influenced the midwife-woman relationship.

Conclusion

This literature review shows the importance of the midwife-woman relationship. The literature described above consistently portrays the emotional and personal qualities the midwife requires to work successfully with women. It also describes how the woman influences how the relationship develops. Most international studies have explored the relationship in a setting where a known midwife is unusual and something the participants have sought, or in settings where the midwife is not known. Many studies acknowledge the social complexity that women experience and how this can impact on midwives. They also recognise the influence of the midwife's work context, which in many situations means insufficient time to support the building of a relationship, particularly for midwives who work in hospital settings and have little control over their workload. Some studies also acknowledge that there are women who do not seek a close relationship, and that midwives struggle to know quite how to care for them.

It seems the profession has struggled over how to describe a close professional relationship. Terminology has included phrases such as the midwifery partnership (Guilliland & Pairman, 2010a), "the professional as a friend" (Walsh, 1999, p. 165), an "anchored companion" (Lundgren, 2018, p. 72) and "being 'with woman'" (Bradfield, Hauck, Kelly & Duggan, 2019, p. 1). It seems there is something in how midwives and women engage in the relationship that does not always sit comfortably with how the profession understands being professional. Van Manen (1997) suggests that phenomenology explores the "very nature of a phenomenon, that which make a some-'thing' what it is – and without which it could not be what it is" (p. 10). It is this something, the nature of the relationship that interests me. There is global interest in continuity of midwifery care and midwives in other countries would like to be able to offer this to women. Indeed, their research seeks to show their decision makers

why the relationship is important. This research will share the learning arising from Aotearoa New Zealand where continuity of care is embedded in the maternity service.

Chapter 3 - Methodology

Introduction

This study uses a hermeneutic phenomenological methodology based on the writing of Martin Heidegger [1889-1976] and Hans-Georg Gadamer [1900-2002]. Such an approach uses not so much a method but a tradition which van Manen (1997) describes as "a set of investigative procedures" (p. 29). This tradition draws on the work of "thinkers" to provide a "source and methodological ground" for phenomenological study (van Manen, 1997, p. 30). Hermeneutic phenomenology takes a philosophical approach which is evident through the entire research (Spence, 2016). My understanding of this approach is evolving, and I acknowledge this is an ongoing process. As the researcher my understanding shapes every part of the study, from what I prioritise in my observation of the subtleties of everyday life, to the texts I have used. This chapter sets out my journey into hermeneutic phenomenology, my understanding of the tradition and how it has been applied. As a prelude to the findings chapters I introduce some of the philosophical notions that underpin this study.

The choice of methodology

Harman (2007) suggests that "philosophy makes things harder rather than easier" (p. 106). This may explain my initial hesitation to engage with hermeneutic phenomenology. Additionally, Heidegger created his own language to convey his meanings and this makes his writing complex and obscure. I do not regard myself as a philosopher and I 'just wanted to know' what made the midwife-woman relationship effective. However, I soon realised that there could be no final truth about something as complex as relationships, but rather that I could gain a greater understanding of the phenomenon. Identifying the 'right' research question influenced the choice of methodology. I wanted to understand the relationship and in what way professional boundaries were important. While other approaches would have provided this learning, hermeneutic phenomenology resonated with what I was looking for; that is, to explore the professional relationship between caseloading midwives and the women for whom they care. Early in my research journey I was advised to trust the process and accept that a greater understanding of the methodology would come. Smythe and Spence (2019) suggest that "trying to understand Heidegger word by word risks losing the spirit of the meaning he was striving to grasp" (p. 4). As I learnt more about hermeneutic phenomenology, I was drawn to the way it provides insights that have enabled me to gain further understanding of the professional relationship, including those I had experienced previously in my own practice.

Thinking phenomenologically throughout the study is important (Tuohy, Cooney, Dowling, Murphy & Sixmith, 2013), and this takes practice. Hermeneutic phenomenology uses stories of the lived experience to gain a deeper understanding of the phenomena. It draws on notions of care and being-with that appeal to my sense of how the world 'is'. Aotearoa New Zealand's midwifery philosophy is based on the understanding that each woman and her birth is unique, and that the midwife is immersed within the woman's experience (Guilliland & Pairman, 2010a). Each relationship is contextual and hence, gives rise to different experiences and understandings of what is truth. For all involved, the relationship is experienced in a manner that gives rise to stories.

Phenomenology: the background

Phenomenology can be traced back to the 18th century with the works of Immanuel Kant [1724-1804], Franz Brentano [1838-1917] and Carl Stumpf [1848-1936] (Robinson, 2006). Edmond Husserl [1859-1938], a follower of Brentano and Stumpf, is regarded as the founder of the modern phenomenological movement (Robinson, 2006). Husserl sought an alternative to positivism that would enable the study of the real life of people (Schneider & Whitehead, 2016). Husserlian phenomenology is described as the study of the essence of consciousness as experienced by that person (Cerbone, 2008). Husserl applied the mathematical term bracketing to describe the suspension of the researcher's own beliefs or ideas, with the intent that this would support a real understanding of the phenomenon (Guignon, 2012). He sought to understand the essence of the lived experience by first understanding one's own conscious state. Such attention to detail underpins phenomenological research.

Martin Heidegger, a pupil and colleague of Husserl, challenged aspects of Husserlian phenomenology leading to the development of interpretative phenomenology (Schneider & Whitehead, 2016). Heidegger believed it was not possible to suspend personal beliefs. Instead, he claimed that the researchers own beliefs should be made explicit, thereby enabling them to be open to their possible influences and to attune to insights that are different to their own (van Manen, 1997). Heidegger argued that a person cannot be understood outside of their environment (Robinson 2006). Rather, the connection between the person and their world was inseparable and that all understanding should consider the influence of this. Such interconnectivity resonates with my world view.

Hans-Georg Gadamer was a student and a colleague of Heidegger, and further developed Heidegger's work. His position was that conversation or connection between persons was what made understanding possible (Dowling, 2007). He describes understanding as a basic structure of our experience of life and argued that it is only through language that Being can be understood (Gadamer & Grondin, 2006). Described as philosophical hermeneutics, Gadamer's approach sought to "understand what is involved in the process of understanding" (Schwandt, 2000, p. 196). While each philosopher has a slightly different approach the underpinning principles of phenomenology remain consistent throughout. That is, phenomenology seeks to uncover matters which are hidden because they are "too close and familiar for us to notice or are buried under traditional concepts and doctrines" (Inwood, 1999, p. 160).

The lived experience

A phenomenological approach seeks to describe the common lived experience of a group of participants who have experienced the phenomenon to be explored (Creswell, 2013). It seeks to understand the human experience by using participants' stories to uncover the "thoughts, perspectives, understandings, feelings and behaviours from the perspective of the person" (Schneider & Whitehead, 2016, p. 96). The phenomenological approach assumes that the human experience is often overlooked amidst other ways of knowing (Smythe, 2011). Additionally, it assumes that we can "best understand human beings from the experiential reality of their lifeworlds" (van Manen, 2007, p. xi). It sets out to challenge assumptions about what is known by making the familiar, unfamiliar, and in doing so uncover new ways of thinking. In this study, midwives and women who have given or experienced care within a context of caseloading midwifery practice, have shared stories of their experiences of the relationship. It is these stories that portray the lived experience of the relationship.

Hermeneutic phenomenology as a method

Hermeneutic phenomenology originated with Heidegger and was further developed by other philosophers including Gadamer (Guignon, 2012). The word "'hermeneutics' derives from the Greek word *hermeneuein* which means 'to interpret' or 'to understand'" (Crotty, 1998, p. 88). The use of hermeneutics can be traced back to ancient Greece when it was used to interpret religious texts (Crotty, 1998). Hermeneutics seeks to gain a deeper understanding than even the author/speaker may be aware of, in part because meaning

and intention may be implicit (Crotty, 1998). Such an approach recognises that "human phenomena are always meaning-laden" (Guignon, 2012, p. 98). That is, what humans do is meaningful. As beings we give meaning to the world of our immediate experience, or the life world that we share, making such meanings accessible to us. Van Manen (1997) states that the "aim of phenomenology is to transform lived experience into a textual expression of its essence" (p. 36). While the concept of essence suggests a fixed truth (Snow, 2009) this is not the case. Rather, phenomenology seeks to gain greater understanding and regards any concept of a final truth as elusive (Smythe, 2011).

Van Manen (1997) argues that hermeneutic phenomenological research requires the researcher to be a scholar. While there is no method, van Manen suggests guiding principles which include:

1. being committed to deep questioning of a phenomenon that interests the researcher
2. investigating the experience as part of it
3. reflecting on the experience to bring to the fore that which may be hidden
4. writing again and again to describe the phenomenon
5. establishing a strong orientation to the phenomenon to ensure it remains central
6. in exploring the parts of the phenomenon the whole does not get lost

Thus, a hermeneutic approach is not linear, rather it works in a circular and reflective way, always back and forth. This means that while the phenomenon being explored remains central, the researcher undertakes thinking to consider the stories, their context and how reading associated literature might uncover new insights (Smythe, 2011).

The phenomena

Phenomenology describes the phenomena, rather than explaining it. It is attentive to detail and considers the significance of that which is taken for granted. It asks about the nature or meaning of the phenomena and offers accounts of the experience rather than developing theory (Guignon, 2012). This methodology does not seek to present generalisations but rather to describe the experience of the midwife-woman relationship as experienced by the participants, and to uncover meanings of that experience. Phenomenology seeks to uncover the "qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1997, p. 107). This is not straight forward. Heidegger describes a phenomenon as something that can "show itself either as it is (in itself) or as it is

not" (Boedeker, 2005, p. 162). That is, the phenomenon may be revealed by its absence. For example, it is likely that the experience of the midwife-woman relationship would reveal the importance of trust if one or other proved untrustworthy.

How we understand our world is shown in our actions and phenomenological research aims to identify these meanings that underpin 'how it is/was' (van Manen, 1997). This can be an elusive concept, since both the participant and the researcher are seeking to verbalise that which cannot be seen and can only be interpreted. This means the researcher must be sensitive to the phenomenon that is being explored and capable of analysis and descriptive writing to convey the possible meanings (van Manen, 2014). There is a tension in exploring the possible meanings behind the behaviour that is seen, or not seen. My interpretation is my understanding of what I have observed, drawing on past and present contexts, and future possibilities as I understand these. This means that all phenomenological description provides just one interpretation of the lived experience. Furthermore, over time as my understanding evolves, my interpretation may surface new understandings. Understanding is always on its way.

Everydayness

Hermeneutic phenomenology sets out to describe the meaning in the everydayness of human beings recognising that "human phenomena are always meaning-laden" (Guignon, 2012 p. 98). It seeks to provide an account of everyday life with a focus on the experience of the phenomena (Schneider & Whitehead, 2016). Heidegger suggests that our understanding of our world is more than what we know and relates to how we go about our everyday business. That is, we go about our lives taking what the day brings and not really thinking to any great depth the meaning of our actions. How we respond and understand each other arises from our own understandings of how it is. The focus of this research is on the everydayness of the relationship between the caseloading midwife and the woman for whom she cares. That is, their responses to the situations that they experience.

Journey of thinking

Phenomenology is portrayed as a "journey of 'thinking'" (Smythe, Ironside, Sims, Swenson & Spence, 2008, p. 1389) that values the unique experience and considers the context within which the experience occurs. Despite not thinking about or reflecting phenomenologically on our experiences as we live them, we are aware of our everyday encounters (van Manen,

2017). Yet to identify and consider these everyday moments of living can be tricky. There are times when trying to put what I wanted to say in words meant that the thought moved away leaving only a glimpse of what might be there. Phenomenological research depends heavily on writing to explain meaning and it is suggested that it is often when rewriting that the insights may come (van Manen, 1997). The writing can take on a poetic approach, describing not only what has happened but also what might happen (van Manen, 1997). Such a process requires the researcher to take an "insightful leap" (Miles, Francis, Chapman & Taylor, 2013, p. 412). Smythe et al (2008) advise that thinking "phenomenologically is not to follow a structure, to solve, to work out; rather it is to let what 'captures thinking' stay in thought and speak to understanding" (p. 1394). They argue that Heidegger encouraged thinking about everyday life that was "free from rules and pre-thought plans" (p. 1396). I found writing to capture my thinking and then returning over and over again was the only way to move past the 'black holes' I experienced. Van Manen (2006) suggests that "the writer must enter the dark, the space of the text, in the hope of seeing what cannot really be seen, hearing what cannot really be heard, touch what cannot really be touched. Darkness is the method" (p. 719). Thus, part of the process is to be comfortable with the uncertainty that occurs before understanding comes.

Given that phenomenology is a way of thinking rather than a method, it seems that holding the thought, turning it over and over, is the only way to gain insights. Understanding comes from a "process of deconstructing and reconstructing, from not understanding to coming to a moment when new meaning and understandings are developed" (Miles, Francis, Chapman & Taylor, 2013, p. 412). Phenomenological research shows the possibilities and invites the reader to consider the researcher's work and to engage in their own thinking (Smythe et al, 2008). This stance acknowledges the boundlessness of understanding. Van Manen (2014) described "hermeneutic phenomenology as a method of abstemious reflection" that avoids "theoretical, polemical, suppositional and emotional intoxications" (p.26). Instead the researcher shows the possibility and the uncertainty that is part of the experience. A core tenet of phenomenological research is that as the researcher I am inseparable from the phenomena under investigation (Tuohy, Cooney, Dowling, Murphy & Sixmith, 2013). Doing hermeneutic research requires reviewing previous understandings, considering cultural and historical influences, and being open to a journey of thinking and writing, and thinking and writing again and again (Spence, 2016). For this reason, I have acknowledged and identified some of my pre-understandings in Chapter one, for this is also without end.

Heidegger: the man and his philosophy

To engage with Heideggerian hermeneutic phenomenology requires pause to consider both Heidegger the man and the pre, during and post World War II context in which he wrote. Heidegger is described as a great thinker who rose above his background and political views (Harman, 2007). His writing can be challenging due to his refusal to adopt the standard terminology of modern philosophy. Instead, he developed new terminology to capture his understanding. It may be that his depth of thinking is hidden beneath his complex writing, however, his texts remain current since they continue to "allow a critique of modern industrial society which many find profound"; it is argued that this refutes the claims that his thinking is "fascistic" (Clark, 2002, p. 134). However, any reading of his texts requires the reader to be open to the possibility that the work is tainted by his connection with Nazism.

Membership of the Nazi party

Concerns relate to not only his membership of the Nazi party or his ambition, but to consider the philosophical ideals of Nazism and whether they may permeate his work (Bambach, 2014). Heidegger was appointed as the first Nazi Rector of Freiburg University in April 1933, and shortly after joined the Nazi party (Clark, 2002). He seemed to be caught up in the mood of the moment and embraced the possibilities he saw for his fellow German citizens. As Germany became increasingly anti-Semitic Heidegger fluctuated between supporting his Jewish friends and colleagues while also supporting those who were overtly anti-Semitic. It is reported that his behaviour over the year of his rectorship was resented by his colleagues. Accounts of his behaviour suggest he loved the theatrical and was caught up in the possibilities he foresaw that would enrich society (Bambach, 2014; Clark, 2002; Harman, 2007). Eventually the German leadership determined that university professors should focus on their teaching and that the party would manage the Third Reich ideology (Harman, 2007). In 1934 Heidegger resigned the rectorship but did not resign from the Nazi party. His reasons for not resigning have been probed, however his decision cannot be considered without also considering the environment he was in. Given what we know of that era it was likely unwise to demonstrate overt withdrawal from the regime.

Making sense of his behaviour

Rockmore (2017) suggests that anti-Semitism was widespread in Germany as Heidegger was growing up and it is likely this would have influenced his philosophy. Germany had been crushed by their defeat in the Great War and Hitler's rise to power created a sense of hope amongst the German people (Bambach, 2014). However, Harman (2007) calls Heidegger's

Nazi aspirations “naïve” (p.99). After Heidegger resigned the rectorship, he retreated to be with his family, disillusioned with the failed reforms, and instead he focused on “past intellectual glories of Germany and ancient Greece” (Harman, 2007, p. 105). Perhaps he immersed himself in the concepts of what he had hoped would come about.

Heidegger is described as a great teacher, but who could be a bully at times (Harman, 2007). It is difficult to understand Heidegger’s apparent lack of self-reflection on his role and that of the Nazi party. It is suggested he was blinded by an ambition to be the “philosophical leader of the National Socialist movement” (Bambach, 2014, p. 110). Following the war, a review of Heidegger’s actions described him as a ‘fellow traveller’; one who while not a main member of the Nazi intellectuals, was a member and supported the party. While he lost his professorship, and was banned from teaching until 1951, he was not imprisoned or executed like others who were found to be involved in the Third Reich (Harman, 2007). However, Young (1997) claims that Heidegger’s “involvement with Nazism was much deeper and much less honourable than the official story makes out”, including that he “abused his position of power” (p. 4). He goes on to state that while Heidegger’s involvement with Nazism was “absolutely disastrous” (p. 6), it was just one part of his life and did not reflect his general character. Instead he proposes that “thinkerly men, human beings in general, are complex, richly inconsistent creatures” (p. 5). Certainly, how Heidegger presented himself and his behaviour could be described as eccentric.

Separating the man and the philosophy

Despite questions remaining relating to his contribution to Nazi Germany, it is his post war response to what had occurred that has been lacking. Heidegger failed to fully acknowledge the horror of what had occurred. When questioned about his role as the rector, Heidegger claimed his work was a “form of ‘spiritual resistance’ to National Socialism” (Bambach, 2014, 107). He argued instead that his work focused on pre-Socratic thinking. He did not apologise for his behaviour or discuss Nazi Germany, although he once described his association with Nazi Germany as his ‘most stupid mistake’. Hannah Arendt, a Jewish woman and his previous mistress, regarded Heidegger’s association with Nazi party as a personal mistake that was separate from his philosophy. I suspect he was embarrassed by his allegiance to what has been described as “the most terrible and violent regime” in Europe’s history (Bambach, 2014, p. 102). I wonder if his ambition caused him to lose sight of what was really happening. Or perhaps it is only with the benefit of hindsight that such decisions are clear.

It is argued that Heidegger's writing through the period of 1920s and 1930s does not appear racist (Clark, 2002). Bambach (2014) suggests that despite Heidegger's silence about the Holocaust there was no "systemic doctrine of biological racism within his writings" (p. 110). However, he goes on to suggest that while Heidegger's writing after 1942 contains traces of his understanding of German exceptionalism, it also includes a critique of National Socialism (Bambach, 2014). Rockmore (2017) suggests that the defence of Heidegger involves separating the man from the philosopher as a "timeless thinker" (p. 154). Heidegger's work focused on making sense of our lives. His philosophy has layers of complexity that open new ways of thinking for those who read his work. While my interpretation is likely to reflect my context and ways of thinking, I have sought to remain vigilant to the possibilities of discrimination.

Guiding philosophical notions

Heidegger drew on his theological studies and argued that it was only through phenomenology that ontology was possible (Crotty, 1998). That is, Being could only be understood through understanding the everyday lived experience. He argued that interpreting that which we encountered immediately would close us to what else may be present. Hermeneutic phenomenology describes structural aspects of humans such as temporality, historicity, thrownness into a world and understanding", however, these do not allow for generalisations in the study of humans, since "humans are 'self-making' or 'self-constituting' beings" (Guignon, 2012, p. 99). Rather these provide the scaffold to create understanding of humans (Guignon, 2012).

The question of Being

Heidegger (1962/2008) argued that the concept of 'Being' was one of the "most universal and the emptiest of concepts", and one that had resisted definition since the ancient Greeks (p. 2). He claimed that we had become complacent about the question of our being and instead needed to be perplexed so that we would start thinking about it (Cerbone, 2008). He set out to develop an understanding of the human way of being by first reviewing that which was regarded as 'self-evident'. He posited that "to work out the question of Being adequately we must first make an entity – the inquirer - transparent in his own Being" (Heidegger, 1962/2008, p. 7). Heidegger looked for a term that was free from "unwanted connotations or prejudices" (Cerbone, 2008, p. 4). This entity he termed as Dasein, a German word, which usually means "existence or presence" (Harman, 2007, p. 174). However, in typical Heidegger fashion, he applied the term to "refer solely to

human existence" (Harman, 2007, p. 174). The complexity of language has meant that different translations have occurred, some of which have included the Da of Dasein "interpreted as 'openness' or 'the open' in the sense of man's being thrown open" (Sheehan, 2015, p. 137), or "to be there" (Inwood, 1997, p. 22). Perhaps in Being we are there and open to what is before us, even if this is in a deficit mode. For example, the woman comes to the relationship and is open to the midwife in a way that draws on her understanding of how relationships are.

Heidegger's understanding of being is informed by our implicit understanding of how to respond to different situations as a person, and this is informed by the society we live in (Dreyfus, 1990). Dasein is always seeking to make sense of itself, even though it is not always aware of this. Thus, understanding arises largely from how Dasein talks and acts because what matters to Dasein influences what it sees (Cerbone, 2008). We can always stop and consider the direction of our lives, but even if we do not, our lives continue in a particular direction (Cerbone, 2008). Hermeneutic phenomenology seeks to make this sense making explicit.

Being-in-the-world

Heidegger did not see things in the world as separate, rather the world is part of our Being, hence being-in-the-world (Miles, Francis, Chapman & Taylor, 2013). The concept of being-in-the-world underpins Heideggerian phenomenology and "refers to the way human beings exist, act, or are involved in the world" (van Manen, 1997, p. 175). The word 'in' is not used in the spatial sense, but rather that humans are open and affected by their world, something Heidegger claimed, that animals and objects do not experience (Harman, 2007). The notion of being-in-the-world includes being able to understand and be part of everything within our world (Lafont, 2005). How we "engage with the world is more significant than the thing that is being engaged" (Tyreman, 2011, p. 304). This suggests that we have choice in how we exist, although this is affected by factors such as our genetic composition, our social and cultural expectations, and the physical environment we live in (Tyreman, 2011). Within this study the woman and midwife come to the relationship with understandings that are influenced by cultural and individual pre-understandings, and these will affect how they engage with the other.

To understand their being, Heidegger suggests that Dasein must continuously question the meaning of being. This back and forth of continuous re-examination leads to an expanding circle of understanding. This circle of interpretation or hermeneutic circle relates to "historical, cultural and personal interpretations through which human understanding is developed" (Schneider & Whitehead, 2016, p. 98). This means that as new understanding arises, previous understandings need to be re-examined. Of course, it is not only what we can see that is important. Harman (2007) states that the "being of things is not their presence at all, since things are always partly withdrawn into shadow, and exceed all visibility and all concepts we might have of them" (p. 4). Hence, it may be that their being is understood by what is not seen. For example, midwives in this study described picking up that the woman was troubled by something and taking time to ask her about what was worrying her.

Being-with

Together with being-in-the-world is the concept of being-with. Dasein does not exist in isolation, but rather encounters other Dasein, and how they are understood is reflected in being-with (Boedeker, 2005). Heidegger (1962/2008) states that "being-with is in every case a characteristic of one's own Dasein" (p. 121). That is, we can imagine ourselves in the other persons situation and can empathise with them (or not) (Inwood, 1999). It is through being-with, that Dasein can share their world. Heidegger suggests that being-with is always in play, even if it is in a deficit mode. For example, a woman participant within this study described feeling alone in her pregnancy when the midwife was not 'present' in their relationship as she had expected. It is through being-with that Dasein is open to other Dasein. The midwife's 'absence' meant that she was not 'with' the woman even though they met regularly.

The notion of care

Heidegger depicts the notion of care, including concern and solicitude as important to how we understand our being-in-the-world (Miles, Francis, Chapman & Taylor, 2013). Care is relational and it is argued that "relationships are not possible without caring or concern" (Miles et al, 2013, p. 411). Care connects us with others around us since caring for someone or something means that person or thing matters to us. Heidegger argued that care, concern, and solicitude are always present, even if this is in a deficit mode whereby the "possibilities of concern are kept to a bare minimum" (Heidegger, 1962/2008, p. 57). I wondered how midwifery care that lacked concern would feel for the woman.

Heidegger (1962/2008) describes being-with-another as moving between two types of solicitude: one that leaps in to relieve the other of care and thus takes over, and the other that leaps ahead to give care back, thus helping the other to be independent. Midwifery care aims to protect physiological birth and enable the woman to become a confident mother (Miller & Bear, 2019). For example, the midwife leaps ahead by sharing knowledge with the woman and encouraging confidence in her own ability, and in doing so, supports the woman to determine what is important to her. Such care was described as empowering for the woman. However, there are times when the midwife must leap in to ensure the woman and her baby are safe, while returning to care that leaps ahead as soon as possible. Both types of solicitude contribute to care that feels safe.

The influence of the 'they'

Dasein encounters other Dasein in the world. In being-with, Dasein's possibilities can become the possibilities of the Other informed by the 'they'. The 'they' refers to the "norms and standards laid by the 'anyone' of which we are a member" (Guignon, 2012, p. 101). What we enjoy in our world, how we behave and view our world, is shaped by what is important to the 'they'. However, what 'they' say may not be defined, nor may it be what Dasein feels or thinks. Nevertheless, our expectations are shaped by those who are around us, be it our family, friends and society, or nobody specific at all (Heidegger, 1962/2008). Within this study, women described seeking recommendations from their family and friends. What they said and recommended was valued by the woman and shaped her expectations of care. This adherence to our world is largely due to tacit attunement rather than following rules (Guignon, 2012). As social beings we are engaged with the norms set out by the people we identify with. Heidegger suggests that to be authentically ourselves, we do not listen to the 'they'. However, it may be prudent to follow suggestions of those who are trusted, or to follow social norms. Hence, inauthenticity was not necessarily a lesser state, but rather one that accepts the recommendations of the they. For instance, women in this study described the voices of 'they', directing how to choose a midwife.

How we sense ourselves

Heidegger uses the German word *Befindlichkeit*, meaning state of mind or mood or attunement. Mood refers to "how we sense ourselves in situations" (Gendlin, 1978, p. 2). Moods are described as the "lenses through which things, people, animals, events, and aspect in the world matter to us" (Freeman, 2014, p. 446). Moods are already there but

may not be noticed (Heidegger, 1995). Dasein is attuned through mood and this "colours and influences every encounter, experience, thought, belief and desire that we have" (Freeman, 2014, p.450). It influences how we experience our world. For example, if I am anxious, I view and interpret the world from this perspective. How I attune myself to my world is a precursor to what is revealed to me (Tyreman, 2013). Women in this study came to their first meeting with the midwife with expectations about what they wanted from the relationship. If the midwife was not responsive to their mood, then they described a mood of disappointment and sometimes looked for another midwife who could respond to them as they wished.

Humanity is 'hard wired' for emotional responses to events, and these occur before the cognitive brain can ascertain what has occurred (Sterrett, 2014). The midwifery philosophy positions midwives to attune with the women they care for so they can be responsive to her needs. Emotions are described as primordial and announce our mood (Heidegger, 1962/2008). For example, we respond to an event by laughing or hesitating without always knowing why, without thinking more deeply. If asked to explain our reaction, we would find it difficult to put into words beyond the sense of, 'it just feels right', or not. Participants in this study described their attunement when the relationship felt 'right' or by feeling a connection with the other person. Such attunement signals to Dasein how they are faring in any given situation (Heidegger, 1962/2008). It is unsurprising that women seek to feel attuned at a time of uncertainty that birth presents. Heidegger described the 'contagion' of moods which enables Dasein to "cope at is best when it forgets itself in absorbed being-with-others" (Dreyfus, 2013, p. 148). This suggests that a positive relationship supports such coping.

We are thrown

Heidegger states we did not choose to be born. Instead we are thrown into our world, facing a range of choices that are set by our cultural context and of which we need to make the best (Guignon, 2012). Thrownness is always present and is seen in the various moods such as fear, excitement, or anxiety that Dasein reveals (Inwood, 1999). Stories from participants in this study revealed their thrownness. The very nature of pregnancy and birth is one of being thrown into situations that cannot be planned or necessarily foreseen.

Fore-structures of understanding

Heidegger's fore-structures of understanding are described as forehaving, foresight and foreconception. Forehaving is an understanding we have in advance that contributes to our interpretation of the situation. This is likely informed by our social context and experience. Foresight draws on forehaving and "refers to the specific perspective or point of view that guides the interpretation" (Lafont, 2005, p. 277). That is, our interpretation. Foreconception is described as something we do or understand in anticipation (Inwood, 1999). We bring our lived experience and knowledge of social contexts to project our understanding of how it may be. In other words, human experience arises from our prior understanding (Lafont, 2005). Imagine a midwife meeting a woman for the first time. I assume this woman will occupy the midwife's full attention as she seeks to understand what is important to her. The midwife will have come to this meeting with an assumption of what is likely to be important to the woman at this time through drawing on her previous experiences. Suppose that during this meeting the midwife reaches an understanding that the woman is looking for particular kind of care that will help her to feel safe. Perhaps she describes feeling extremely anxious and asks the midwife many questions, and the midwife despite trying her best, feels her responses are not reassuring to the woman. The midwife will draw on foresight to inform her of how this relationship may play out. Her foreconception will likely influence how she responds to the woman, whether she looks for a way to meet the woman's need, or perhaps puts limits on her availability.

Structure of the lifeworld

Heidegger described four lifeworld existentials (time, space, body, and relationality) that describe how all human beings experience the world, albeit in different ways (van Manen, 1997). These concepts do not relate so much to the memory of events, but how these are felt. Participants in this study were asked to talk about their experience of the midwife-woman relationship. The stories that participants shared described their experiences and at the same time, revealed more about the nature of their being-in-the-world.

Lived time (temporality)

Lived time or temporality is described as "subjective time as opposed to clock time" (van Manen, 1997, p. 104). It refers to the experience of time seeming to 'fly' when we are engrossed in an activity or 'crawling' when we are bored or anxious. Women in the study described their time with the midwife not in clock time but by the feeling that the midwife had all the time in the world for them. Heidegger described time using a threefold structure that

considered past, present, and future. For instance, the woman's previous experiences inform her about how it is likely that this relationship 'is', what possibilities the relationship may hold, and how she may engage in the relationship that is currently before her.

Lived space (spatiality)

Lived space relates to how we experience the spaces we enter. This is largely sensed rather than thought out and affects how we feel (van Manen, 1997). The experience of walking into the space of the hospital can be reassuring for many women, but for some it is frightening. Much may depend on the purpose of their visit and how in control they are feeling at the time. Midwives are aware of such feelings and leap ahead to prepare women for that possibility. On the other hand, our home is described as an inner sanctum where we can feel safe and be ourselves (van Manen, 1997). How we understand our lived space reflects how we understand ourselves. Participants in the study noticed the difference in the relationship when the midwife visited at home and reported that the home space meant the relationship felt closer.

Lived body (corporality)

Corporeality refers to that we are always physically in this world. How we show or hide ourselves, not necessarily in a conscious way, contributes to how we are understood (van Manen, 1997). The lived body also responds to how the other regards it. For example, imagine how "under a critical gaze the body may turn awkward, the motions appear clumsy, while under an admiring gaze the body surpasses its usual grace and its normal abilities" (van Manen, 1997, p. 104). Midwives have experience in interpreting the meanings that lie behind the woman's body language and relate to this when providing care. The midwife observes the woman for any changes in her wellbeing throughout her pregnancy journey in a way that sets out to be unobtrusive. How well they do it may reflect on whether the woman feels watched or not.

Lived human relation (relationality)

Relationality refers to "the lived relations we maintain with others in the interpersonal space that we share with them" (van Manen, 1997, p. 104). This relates to first impressions we make of each other upon meeting face to face. Participants described the importance of relationality for the midwife-woman relationship and how the first contact with each other set

the scene for how the relationship may be. The nature of relationality is what this thesis seeks to reveal.

Gadamer

While Heidegger brings understanding as being-in-the-world, Gadamer expands his ideas to shed light on the interpretive nature of understanding. Hans-Georg Gadamer was born in Southern Germany. Upon completion of his PhD he worked with Heidegger at Marburg University. Criticism from Heidegger led to Gadamer changing from philosophy to classical philology. Despite tensions in their relationship, he remained relatively close to Heidegger throughout his life (Stanford Encyclopaedia of Philosophy). Unlike Heidegger, Gadamer did not join the National Socialist Party, nor did he affiliate with them. Rather he kept a low profile and avoided politics (Dostal, 2002). A review after the war found that he was not linked to Nationalism, and this led to him becoming Rector of Leipzig University. While it has been suggested that Gadamer may have supported the Nazis in some way, and that some of his work had included fascist notions, this has been refuted by Gadamer scholars (Lawn & Keane, 2011). Gadamer himself stated that he "silently kept his head down and kept quiet while intellectually refusing to give the regime credence or respectability" (Lawn & Keane, 2011, p. 80). Undoubtedly, had the regime seen him as a threat it is likely his life would have been significantly different. The focus of Gadamer's work was on interpretation of text using everyday language, rather than "creating a special language" as Heidegger had done (Dostal, 2002, p. 30). The text in this research comes from the transcribed texts and stories from the participant's interviews.

How we reach an understanding

Gadamer regards language as the core to understanding for it is through language, both spoken and unspoken, that an understanding is reached (Palmer, 1969). He argues that it is by engaging in conversation the parties can establish common ground, and in doing so something else is created, something "that comes to presence in conversations" (Weinsheimer & Marshall, 2013, p. xvi). This is because neither of the parties know in advance where the conversation will go. For even if they had planned in advance what may be said, neither know how the other will respond. In speaking with one another aspects are shared, and this may contribute to an understanding of the character of the other, including whether the other is trustworthy. But there are times when language fails us, such as when words are not able to fully grasp what it is that we wish to say. Even so,

this remains a form of language since it communicates what is not said. Hence, the skill of hermeneutic phenomenology is to interpret what is said and what is assumed.

Gadamer advises that conversation does not force the opinion of one onto the other, but instead creates a new interpretation of understanding. He suggests that poetry is the original language of humanities because within "artistic presentation is recognition, which has the character of genuine knowledge of essence" (Gadamer, 2013, p. 119). Hence, this research seeks to create an account from the participant's stories that captures the essence of the midwife-woman relationship in a way that hints, suggests, or shows what might be possible. Yet the reader will bring their own understanding and interpretation to this writing that may be beyond anything that I as the researcher had envisaged.

Gadamer suggests that when misunderstandings arise these may be due to assumptions in prior agreements of understanding. He suggests that understanding arises when there is a clearing of misunderstanding and a bridging of the I-Thou. Gadamer (2013) claimed that the "experience of the Thou must be special because the Thou is not an object but is in relationship with us" (p. 366). He describes the Thou relationship as one of symmetry where neither are dominant, but instead engage in a mutual relationship that respects the other's self and autonomy. While this related to his interpretation of texts, the same concepts can be considered in human relationships. Participants in this study described close relationships that included aspects of reciprocity. Such relationships were special to them and coloured their experience of the childbearing journey.

The play of conversation

Gadamer (2013) suggests we "fall into conversation" never knowing quite what will be revealed since it is in the back and forth or 'play' of conversation that substantive understanding arises (p. 401). It takes time for the conversation to develop and reach its conclusion, but in doing so each is revealed to the other and they come to understand if the other is trustworthy. Play joins people together in a shared activity with each player contributing to a new understanding. The notions of trust and shared understanding underpin midwifery suggesting that 'allowing' time for this activity is an important investment for midwifery care.

Towards a fusion of horizons

Gadamer explored the historical and cultural influences on human understanding (Gadamer, 2013). He argued that people's consciousness is affected by their history and the culture that shaped them. Therefore, they come with a pre-understanding considering "past, present and future understandings and potentially what is said and not said" (Spence, 2016, p. 3). Gadamer described these preunderstandings as prejudices and that these affect how we interpret the situation in which we find ourselves (Schwandt, 2000). This means that to reach an understanding we must engage with our bias and prejudice to make these explicit. I sought to identify and explore my prejudices and took time to consider how these may support or limit my understanding (Spence, 2016). This included an interview by my supervisor to explore my experience of the relationships between myself and the women I cared for as a caseloading midwife to begin to uncover the assumptions that I held. My pre-understandings in chapter one lay out my positioning. Additionally, a reflective journal contributed to surfacing further assumptions and prejudices throughout the research journey.

Gadamer argued that it is only through mediating our past and present influences, that a shared understanding can be reached. He described this as a fusion of horizons (Crotty, 1998). A merging of horizons does not assume that both have reached the same understanding. Nor does it mean that the other discards their prejudices. Rather, they have a new understanding of alternate possibilities from their own viewpoint (Svenaeus, 2003). This means that because the prejudices remain, the person may need to test them, repeatedly. Consequently, the understanding that does eventuate is likely to be "broader and more complex, multifaceted understanding. Moreover, because horizons are essentially open, the fusion is ongoing" (Spence, 2016, p. 3). Both midwives and women in this study described how the conversations they engaged in brought them closer to the other person in the relationship by enabling them to see the other person's point of view. This was even if the midwife had a different understanding of what might be best for the woman. Gadamer argued that in a true conversation, both enter wanting to be convinced by the others' claim. Thus, the goal of communication was to be open to the possibilities that lay within the conversation.

Conclusion

This chapter has described how I have engaged with hermeneutic phenomenology and some of the key philosophical notions that have guided this study. I have provided examples

of how these link to this study. The woman and midwife come to the relationship with their previous experiences and understandings of how the relationship may develop and these affect their ongoing experience of the relationship. Exploring the midwife-woman relationship requires the kind of deep thinking that the works of Heidegger and Gadamer lend themselves toward. Yet as I open the possibilities, I am aware of more that lurks beneath the surface. I admit to feeling perplexed by the concept of the midwife-woman relationship, knowing my recognition of all that I do not yet understand is the way of hermeneutic phenomenology.

Chapter 4 – Method

Introduction

As phenomenological research has a philosophical basis, every aspect of the research must show congruence. This means that the research question, aims, methodology and methods must reflect a phenomenological way of working within the world. Hermeneutic phenomenology has required me to 'just do it', learning along the way what felt 'right' and most importantly, what was consistent with the tradition. The reading of works by Heidegger and Gadamer, alongside other authors who have sought to provide their interpretation, have guided my thinking. This chapter describes how hermeneutic phenomenology was applied to this study, including each part of the research process.

Engaging with pre-understandings

As a midwife I feel well placed to explore the nature of the professional relationship, something that 'just happens' when the midwife engages in caring for the woman. However, van Manen (1997) cautions that knowing so much can be a disadvantage to me as the researcher, since my assumptions and pre-understandings of how it 'is' can lead me to begin interpreting before I really understand the meaning of the phenomenon. However, he suggests that we cannot "forget or ignore what we already 'know'" (p. 47). Hence in chapter one I described aspects of my background as an outline of my pre-understandings of the midwife-woman relationship. I have also sought to be open to any assumptions that I have made by taking time to think about other perspectives that may be present. I was interviewed by my supervisor before I began any interviews, to help identify my pre-understandings of the topic. Initially I found it difficult to remember stories, perhaps because they were drawn from several years ago. This made me realise I would need to give participants time to think and perhaps have additional prompts. I acknowledge that any understanding of the language and subtleties of the midwifery profession and its history, is from my point of view. For this reason, within the interviews I sought to ensure that basic understandings were clarified either within the interview or when reviewing the transcripts.

I recognise that my role as the researcher has influenced every aspect of this study, including who participated, how the conversations played out, and what is presented in this final thesis. I knew most of the midwives who participated and identified with many of the contexts they described. I suggest that my prior relationship may have contributed to their participation because they trusted me to hear their story, and that I would treat it with respect. In turn, I hope that this account affirms their trust in me. Van Manen (2007) suggests

that “text must reverberate with our ordinary experience of life as well as with our sense of life’s meaning” (p. 26). I trust that will be evident throughout this study of the midwife-woman relationship.

Trustworthiness of phenomenology

The concept of rigour in qualitative research has been challenged by the positivist paradigm, with the onus on the researcher to demonstrate the research is trustworthy (Koch, 1996). Researchers have suggested that the notions of reliability and validity are relevant to understanding the quality of the study (Merriam & Tisdell, 2016; Morse, 2015). Validity may be shown by the reader recognising the description of the phenomenon, while reliability relates to the ability to get the same results if the study was repeated. However, the concept of reliability is problematic in phenomenological research since human behaviour is always changing. Furthermore, revisiting the data is likely to uncover new understandings, as I have found throughout this study. It is suggested that a description about how data were collected, how categories were developed and how decisions were made provides an audit trail for the study and that this demonstrates reliability.

The notion of transparency, that is, ‘how we know’, is important in research (Trainor & Graue, 2014). As such, I have described my thinking and the processes I followed throughout this study to provide the reader with an understanding of the decisions and contexts that supports this study. I have provided reasons for why a particular method and interpretation has been privileged over another, given the multiple understandings of reality (Creswell, 2013). I have sought to make my bias explicit acknowledging that there will be assumptions I have made of which I am unaware (Creswell & Creswell, 2018). I have included the participant’s own words before providing my understanding. This level of detail assumes that when the reader is supported to understand the decisions that have been made, they can reach their own conclusions about the trustworthiness of the research findings.

While this detail provides a description of what has been undertaken there is another aspect to trustworthiness that is much harder to quantify. Merriam and Tisdell (2016) suggests that “the validity and reliability of a study depend upon the ethics of the investigator” (p. 260). Because phenomenological research involves talking with people, it is my social skills as the researcher that influences the ethics of this study. Things such as my ability to pick up on whether the participant is comfortable sharing their story, or whether there is something

unsaid that they need time to share. Sandelowski (2015) uses the notion of taste to describe the assessment of qualitative research. Like appreciation for art or fine wine, the reader becomes attuned to research that is valued because of its quality rather than using a specific criteria.

This is echoed by van Manen (2014) who suggests it is the "appraisal of the originality of insights and the soundness of interpretive processes" that demonstrates the validity of phenomenological research (p. 348). He suggests that high quality phenomenological text may be recognised by the experience of reading it, for this reading will draw us in with ah-ha moments and moments where we are consumed by the telling, where we are also there in the moment, and maybe gaining insights into our own experiences. Van Manen (1997, p. 27) also describes the "phenomenological nod" that occurs when the audience recognises the description of the experience as something likely, something that resonates with them. Additionally, Smythe et al (2008, p. 1396) describe the "profound sacred silence" that occurs when the audience identifies with the described phenomenological experience. Such responses affirm the shared understanding and relatability to the phenomenon being explored. Thus, trustworthiness is found when the findings resonate with the participants and those who have an interest or experience of the phenomenon (Smythe et al, 2008).

Am I thinking?

It is suggested that philosophy begins with wonder, a disposition that "dislocates and displaces us" (van Manen, 2014, p. 37) and leads to genuine thinking. Heidegger suggests that it is only by thinking that we learn to think. However, he went on to claim that we are not thinking, not even himself, and that this was part of being (Harman, 2007). He provides an analogy for the thinker in the carpenter, who on examining a piece of wood looks for the best way to work with the wood to fashion something that was all the time already present, but perhaps hidden (Harman, 2007). In working with the grain of the wood the carpenter (or craftsperson) seeks to reveal the beauty that is within. Such a notion appealed to me and led me to wonder if I could uncover the phenomenon that was already present in the stories of the midwife-women relationships.

As I write this thesis the world is in the throes of the Covid-19 pandemic where we at once face our mortality but also have been made to slow down. Thinking involves slowing down (though preferably with less angst) and taking time to be reflective. It involves sitting with the

thought and turning it over to consider it in other possibilities. It involves being open to the wonder of what might be happening, to what else might be present. Sitting with the information was important to give me thinking space to consider the possibilities that were hidden in each story (Smythe, 2011).

To support my understanding of hermeneutic phenomenology I attended a reading group which considered various related writings. I sat in awe of those who had almost completed their study. They spoke with a confidence and knowing about complex writings that often eluded my comprehension. It was only recently that a new student joined the group that I found I understood the concepts behind the questions she asked. Discussions with my supervisors has supported my thinking and opened ways of understanding that has been vital. Additionally, discussions with colleagues have allowed me to sound out concepts to get a feel of how they feel in the light of day.

The hermeneutic way is to read widely of anything. Throughout the study I read from topics and ways of writing which included midwifery, about the health service, from psychology, sociology, leadership, emotion work, about the hero journey and about professionalism. Reading gave me insights to the possibilities within the data I had gathered. Throughout this work I have linked the articles that sparked my thinking to show my journey through the data. When I got stuck, I went back to reading philosophical texts, and if still stuck, other texts. Hence, literature is included not only in the literature review but also throughout the findings and discussion chapters.

Ethical approval

I sought ethical approval to interview up to 24 participants. This comprised of 12 caseloading midwives and 12 women who had received midwifery care from a caseloading midwife within the last three years. The Ethics Committee sought eight minor amendments and clarifications to my initial application. Once that was provided, ethical approval was given by Auckland University of Technology Ethics Committee (AUTEC) in August 2016 (see Appendix A).

Research in Aotearoa New Zealand considers the principles of partnership implicit in Te Tiriti O Waitangi (Health Research Council of New Zealand, 2010). Māori midwives and women make up the community that have experienced the phenomenon being researched. As part of the ethical approval process I met with the kaiawhina (a cultural assistant) at the Waikato Institute of Technology to discuss this study and gain guidance. Additionally I reviewed documents that provided guidance when undertaking research with Māori (Health Research Council, 2010; Hudson, Milne, Reynolds, Russell & Smith, 2010). The principles of relationships, justice, equity, and cultural sensitivity resonated with my world view and I aimed to keep these forefront throughout the study.

Consent

Potential participants were sent an information sheet when I began recruiting (see Appendices B, C). This described the research project and included information about consent and withdrawal. Formal consent was obtained before starting each conversation and participants were reminded that they could withdraw at any time prior to completion of data collection (see Appendix D). As agreed in the ethics application, the completed consent forms have been kept secure by the primary supervisor and will be destroyed after six years. Recordings and transcripts have been kept on a password protected external hard drive which will also be destroyed after six years.

Confidentiality

Throughout this study I recognised that midwives in Aotearoa New Zealand are a small group and so may be identifiable by their responses within this study. Once I received the transcripts participants were allocated pseudonyms for use in the study and all identifying data were anonymised to reduce the likelihood of breaching confidentiality. I found over time I came to know the data by the pseudonym, however, there remained some phrases or tracts that took me back to the moment when the participant shared that particular information. I recognised that this reflected my emotional response to what they shared at the time. This suggested that what they said had particular meaning for me and so I took time to consider the meaning underlying why their words were important to me.

I was cognizant that most of the women who participated were not known to me. I considered that they may feel vulnerable when disclosing their experience to me, or that they may be concerned that as a midwife I would not be open to hear their story. To mitigate this, I sought

to be sensitive to the topics they raised, including any negative experiences they shared, while reassuring them of the confidentiality of their contribution. I sought to be non-judgmental in my responses including body language and to listen carefully to the woman's story.

I was mindful that as a result of sharing their stories the participants may have heightened awareness of any issues that arose from revisiting their experience. Therefore, all women participants were provided information regarding the complaint and feedback processes that are available through the College of Midwives, Health and Disability Commissioner (HDC), and the Auckland University of Technology (AUT) counselling services. All midwife participants were reminded about the availability of the Employee Assistance Programme (EAP) and College of Midwives support services. They were also advised that should they feel the research process was harmful they could access three free counselling sessions from AUT. All participants were provided with the contact details for these services.

Ethical issues

Within the conversation participants shared information that included aspects that were confidential and/or sensitive. I was mindful of my responsibility to protect this information. One of the women participants shared a story of a birth that had not gone well for reasons that she did not seem to understand. I provided her with contact details for the College of Midwives resolution process as well as the AUT counselling services. I followed up with her after she reviewed her story and at that stage, she had not accessed any further support and assured me all was well. I discussed my concerns with my supervisor, and I left it at that. The woman contacted me many months later and advised she now wished to talk to someone about her concerns and so I gave her the contact details for the services she requested. At a chance meeting while taking a walk alongside the riverbank, she shared that she had attended the counselling and support services found these very helpful and expressed her gratitude for my support.

How were participants recruited?

Phenomenological research seeks participants who have experienced the phenomenon that is being explored. Therefore, participants were recruited using purposive sampling and snowballing to ensure participants had experience of the phenomenon being explored.

Recruiting midwives

The information sheet was sent by email via an intermediary (Waikato Institute of Technology) to midwives within the Bay of Plenty, Waikato and Auckland regions of the upper North Island who met the inclusion criteria of:

- currently or recently worked in a caseloading role in Aotearoa New Zealand
- able to articulate their understandings of their professional relationships with women they work with

A greeting in Māori was included on the participation sheet to acknowledge the bicultural society of Aotearoa New Zealand. The midwives were invited to contact myself as the researcher by phone or email if they were interested in participating in the research. I did not contact any midwives directly. Nor did I hold a list of who had been sent the information sheet.

Recruiting women

The other group of participants were women who had accessed caseloading midwifery care within the previous three years, and who spoke understandable English. Anecdotal evidence suggests that when something matters it is remembered long after the event however, three years was chosen as a time frame to keep the stories within a common context. I sought permission from managers of services that mothers may access, such as well child services or General Practitioner rooms, to place flyers seeking participants. Around the same time the information sheet for women participants was included in a weekly health update from the local District Health Board that was sent to health professionals and women's groups in the wider region. Midwives across the wider geographical region also shared the information sheet with some of the women they had cared for who they thought might be interested. Two women were recruited in this way. I was mindful if being encouraged by their midwife to participate would change the dynamics of their interview. However, both women had very different stories to share and only one of the midwives was also a participant. Both spoke of other relationships aside from their current one. The stories from that midwife and woman were not linked or compared to consider their specific relationship. Additionally, women participants shared information with their friends leading them to contact me to participate. There was a delay in gaining permission from the managers of services and before that had been actioned, I had recruited sufficient participants from my other networks. I did not contact any women directly.

When potential participants contacted me, I asked if they had any further questions about the study or the interview. I also explained the commitment to participate in an interview and review their crafted story. They were advised about their rights to withdraw. As all stated they wished to proceed we negotiated an interview time and venue to meet. I did not expect to know the women who participated. However, Aotearoa New Zealand is a small community and I found that some were known to me as acquaintances through my work. I had not provided midwifery care to any of the women who participated.

Demographic profile of participants

I did not gather specific demographic information on the participants. Phenomenological research does not set out to generalise findings and so representation of Aotearoa New Zealand society was not sought. Rather, the emphasis is that the participants have experienced the phenomenon that is being explored. Ethnicity was not recorded. However, midwives who participated included those who:

- had recently left caseloading practice (within the last year)
- worked in a rural practice
- worked in a city or in urban centres
- were married or single
- with children of varying ages and without children
- had been in caseloading practice for many years
- had recently graduated and were new to caseloading practice
- had previously or now worked in hospital settings
- gained their midwifery qualification overseas and in Aotearoa New Zealand

The women came from a range of geographical locations and contexts including they:

- lived in rural locations
- lived in urban and city locations
- had positive and/or negative experiences with midwife relationships
- had birthed at home and in hospital
- had first, second or third babies
- were aged in their 20s and 30s
- identified as a woman from the Pacific

Reflexive writing

Researcher reflexivity is an important aspect of the trustworthiness of phenomenological research to make the embedded role of the researcher explicit. As a midwife I engage in reflective practice to support my own professional development as part of being a midwife. This usually entails thinking about events in a way that supports insights for learning. These are usually short and capture the mood of the moment. Within this study I kept a reflective journal to help make explicit the decisions that were made regarding the development of the research including recruitment of participants, responses to data, and decisions about the development of themes. In making my understandings explicit I seek to provide a bridge to the participant's understanding that is explicit for the reader, while also realising that the reader brings their own understanding and interpretation to this study. What is apparent in reading through my journal entries is the circular way through reading and writing over and over again, that supported me to gain an understanding of both the data and the process of undertaking hermeneutic phenomenology. I acknowledge that this is never ending since I could return to the text at an undetermined time in the future and find something 'new', which of course will have always been there, but is then revealed by the changes in my understanding that come with time. Accepting not getting 'there' has been part of my journey.

Data collection

Data were drawn from interviews which were transcribed and then crafted into stories, as well as my pre-understandings and research journal. The interviews were conducted between October 2016 and September 2017. Table 3 provides a summary of the data collection.

Table 3. *Summary of data collection.*

Participants	Activity	Numbers	Time
Midwives	Interview Read crafted story and clarify if required	9	1-1 ½ hour interview ½ hour review crafted story
Women	Interview Read crafted story and clarify if required	8	45-60 minute interview ½ hour review crafted story
Researcher	Reflective journal Identify self-understandings		Ongoing 1-hour interview

The phenomenological interview

Phenomenological interviews are more like a conversation (van Manen, 1997). The conversation seeks to gather the participant's stories of their experiences and then use these to develop a "richer and deeper understanding" of the phenomenon (van Manen, 1997, p. 66). It does not seek to interrogate the participant about their experiences, rather to explore the participants' experience through a conversation that flows. The openness of the conversation meant that each interview was unique and reached its own destination, yet with sufficient direction to meet the requirements of the research topic (Smythe et al, 2008). There were times when I would seek clarification. Additionally, there were times when the participants' replies provided direction that I had not previously considered (Robinson, 2006). I took time to prepare before the interview so that I felt calm and open to what might be said. I found I enjoyed the interviews, particularly hearing each person's stories. Sometimes I would get carried away in my response and catch myself, remembering that my role was to mostly listen to the conversation and prompt, rather than contribute my understanding. While aspects of reciprocity supported the conversation to continue in a more natural flow, I was mindful that my contribution could alter how the participant responded.

The environment

Preparation and ensuring an environment conducive to conversation was important (Denscombe, 2010). A safety protocol for myself had been developed as part of the ethics process and this was followed (see Appendix E). Prior to the meeting participants were advised that the interview would be for approximately one hour. Conversations with the women participants lasted between 35-60 minutes, whereas conversations with the midwives were usually 50-80 minutes. As we neared to 60 minutes, I checked with participants if they were all right to continue and all agreed. It seemed that midwives had a lot to say about the topic. Although it could be that I knew most of them through my professional work and we shared a similar professional background.

Although we had spoken by telephone previously or were known to each other, at the start of each conversation I re-introduced myself and explained the study and asked if there were any questions. Next, the participants signed a formal consent and I verbally reminded them of their right to withdraw. When participants shared situations that had been difficult, I acknowledged their challenging experience. Throughout the conversation I looked for any signs that the participant might be uncomfortable with any questions or with the story they

were sharing. When they ended each part of their story, I sought any clarifications rather than interrupting them as they were talking.

The interviews were held at a location determined by the participant and at a time that was suitable to them. The participants were drawn from a wide geographical area and this meant I travelled to meet with them. They determined where would be suitable to meet, considering the need for privacy and quiet, and I followed their preference. The women mostly preferred to meet with me in their homes. However, the reality of women's lives became apparent early in the interviews. Some women had responsibility for their children who despite their best plans, were not always asleep. This meant they were sometimes distracted from the conversation by the needs of their child/children. For two women we were interrupted, and I checked with them whether they wished to proceed with the conversation, but after attending to the immediate need they advised they wished to continue. One woman asked to be interviewed at her place of work and two women requested to be interviewed via Skype. I was not sure how well this would go as I did not know them previously and I did not feel experienced in interviewing online. I wondered if I would be able to pick up on the subtleties of their language or make the same connection with them, or whether this would affect what they shared with me. Both lived in remote rural locations meaning access for a face to face interview would be more difficult. I decided to put aside my preference for a face to face meeting and trust that if they were confident then everything would be alright, and it was. Both participants were open and forthcoming about their experiences and I soon overcame my initial concerns.

Six of the midwives requested to meet in a private room within a workspace, either at a birth centre, clinic or at the midwifery school. One requested to meet at her home, and one requested to meet via Skype. By this time, I had confidence using Skype for interviewing and so agreed to her request. Most of the midwives were on call and two received calls during our interview. Each time I paused the recording and waited until the call was finished. Before commencing we had agreed that the midwife would indicate to me if the call required her full attention or was one that she wanted privacy, so I could leave the room. I left the room for one call, but the other call was completed in a short time. The midwives were loquacious and shared a wide range of stories from their practice as examples of their relationships with women.

Listening carefully

Being alert to any non-verbal cues including body language and listening intently to the conversation was an important part of the interview (Koch, 1996). I found listening attentively hard work and sometimes my mind would drift off, thinking about something the participant had said that interested me, only to pull myself back to focus on what the participant was saying. There were times when I needed to sit with the silence to allow the participant to think through what it was that they wished to share. Other times I needed to prompt the conversation again with a further question or to clarify or sum up aspects of what had already been said.

Before starting the interview, I asked the participants if they were comfortable with me taking notes so that I could follow up on anything I wanted to know more of, without interrupting their flow of conversation. All participants agreed. I sought to position myself so I could write discreetly and not distract the participant from what they were sharing. I tried to write without looking at my notes using key words only, so that my focus remained on the conversation at hand.

I audio recorded each interview. I had practiced with the recording device first to ensure I was confident with how it worked and what range it had to ensure the conversation was recorded clearly. It was a small device and unobtrusive, so I placed it on whatever piece of furniture we had between us. I carried spare batteries for the recorder and kept an eye on the red light, always mindful that the device could fail. However, it did not.

It seemed that being listened to was important for the participants. One woman sent an email thanking me for listening to her story and said she had urged her friends to participate as she had found the experience healing (private communication). A midwife shared that she felt that talking to me had been more useful to her than the counsellor she had attended previously (following an adverse outcome).

Indicative questions

The skill in hermeneutic interviewing is to keep the conversation open while also remaining focused on the research topic (van Manen, 1997). A list of indicative questions that reflected the research question and aims was used as a prompt for the conversation (see Appendix

F). Participants were asked to think about experiences of the midwife-woman relationship and recount stories, incidents, or anecdotes. These included experiences of when the relationship went well and when it did not. I asked them to recount specific examples of their experiences and then explored that experience by using clarifying questions to gain a greater understanding (van Manen, 1997). I used open ended questions starting with 'tell me about a time'. Not all questions were used for every interview as some participants had already discussed the area the question probed while telling another story. Within the first interviews it became apparent that the first meeting between the midwife and woman was important, and so I added a question to subsequent interviews to prompt this discussion if it had not already been included.

How much is enough?

While I noticed that the participants were sharing similar stories, I was keen to continue with interviews, just in case anything new surfaced. I was aware that some voices were missing. I was assured by my supervisor that I had more than enough data to analyse and that I should move on to the next stage. I noticed that the interviews with the midwives were usually slightly longer (1-1/2 hours) compared with the women (45 minutes). Women and midwives bring different expectations to the relationship. The experience is a significant life event for the woman and this contributes to the emotional intensity she may feel. On the other hand, midwives engage in relationships with women as part of their everyday work. Where the woman may have two or three births, the midwife is involved in multiple birth experiences through her midwifery practice life. As well, midwives have been grounded in the art of self-reflection so they continuously learn from their practice experiences and this informs how they engage in future relationships. This is further tempered by professional obligation and culpability. This probably leads to the midwives exploring the relationship in greater depth, and so have more to say.

Phenomenological research does not seek to generalise findings. Rather the focus is on telling the stories of the participants and interpreting their everyday lives to surface new understandings of the phenomenon being explored (van Manen, 1997). This means that the concept of saturation is not appropriate in hermeneutic phenomenology. Therefore, this study focuses on the stories of eight midwives and nine women who have experienced caseloading midwifery.

Working with the stories

Stories in hermeneutic phenomenology provide the story teller's experience of events and this includes their relationship to others. Mood influences what is important to us and so changes how we tell our stories and how they are heard (Crowther et al, 2016). While we may not remember exactly what occurred, we are likely to remember how we felt at that moment. For example, in this study a woman's thrownness was revealed when she could not remember whether her midwife had been 'there' for her during the postnatal period while she was in the hospital. Rather, she remembered feeling alone. Thus, her mood coloured her memory of the experience.

Transcribing

Each interview was audio taped and transcribed by a professional transcriber, who signed a confidentiality agreement before commencing transcribing (see Appendix G). When the transcriber was not sure of a word, she left a blank in the transcript along with the time on the audio for me to check the recording. In each case I could identify the word on the recording due to having a deeper knowledge of medical terminology or from my memory of the conversation. I read through the transcripts while also listening to the original recorded interview to confirm the transcription was accurate. This also enabled me to feel I was familiar with not only what the participant said, but to revisit how it was said, including any hesitations or laugher, since these all contribute to the data (Robinson, 2006). Listening to the recorded interview also gave me the opportunity to listen without needing to respond.

Crafting stories

Verbatim transcriptions can be an awkward way to review the participants' thoughts as they are interrupted by idioms of speech. Hence, the transcribed interviews were crafted into a 'story' using the participants own words. Caelli (2001) suggested that the word 'stories' implied that it may not be true, and that the term 'anecdote' hinted of unreliability. Thus, she applied the term "narratives of experience" (p. 278). Alternatively, van Manen (2014) suggested that an "anecdote is to reflect, to think" and that they tell us what matters in a focused way (p. 250). While midwifery practice is underpinned by evidence-based research, there is also a tradition of sharing our everyday experiences and learning via stories. These stories describe the individual experience including relationships and ways of caring. Such story telling does not assume to provide the thinking or describe the event in its fullness. Rather, it tells the story from the story teller's perspective. Phenomenological research assumes that each story holds multiple meanings and that interpretation is ongoing to

uncover the phenomenon. The credibility of such data is revealed by "how it resonates in felt, shared plausible meaning, and this resonance cannot be reified into proof" (Crowther et al, 2016, p. 3).

Analysis involved working with the data to be open to the possible meanings that are present. To craft the stories, I drew on the work of Caelli (2001) and Crowther et al (2016) as follows:

1. read the full transcript many times to gain a sense of the data, including listening to the recorded interview.
2. removed detail that did not add to the story, such as if it was unrelated, identified the participant, or was repetitive
3. re-ordered sentences to ensure the flow of ideas and appropriate grammar
4. reviewed the original transcript for anything I had missed, and which now seemed important to include
5. re-read to ensure the story flowed and captured the participant's own words and intent.

I found some parts of writing the stories challenging as I worried about what was 'the' essential meaning, and whether I would miss it if I edited too enthusiastically or too soon. This took me back and forth between the developing story and the original transcript to ensure that I had it 'right' in a way that resonated with my overall understanding of the participant's story (see Appendix H for an example). Each completed story was then sent back to the participant to review and verify the information.

It is suggested that checking of stories by participants is not consistent with hermeneutic phenomenology since stories are constantly changing with each telling as the teller privileges that which matters to them (Crowther et al, 2016). On the other hand, Dowling (2007) argues that feedback and discussion with participants is consistent with Gadamer's hermeneutic circle. It felt 'right' to return the crafted stories to the participants to review and comment on. I was aware that this could open the way for further thinking and clarification, and I accepted that as part of the process of hearing their stories. Most participants agreed that the words and intent resonated with them and they were happy for me to proceed with no further changes. However, two of the midwife participants suggested corrections that related to grammar. While some editing occurred, they were also assured that only parts of their crafted story would be included in the final thesis and that any grammatical issues would be

amended then, ensuring that the intent was unchanged. They then advised that they were happy for their stories to continue.

Interpretation of the stories

Hermeneutic analysis requires the researcher to sit with the stories, moving between the words and the whole story looking for hints of the phenomenon (Crowther et al, 2016). First, I read the story of each participant, considering each paragraph for possible meanings. I would 'sit' with the paragraph for a time, writing and thinking, trying to tease out the meaning within the words. This back and forth of writing and thinking is part of hermeneutic study (Smythe & Spence, 2012). Detailed reading considered every sentence and related this to the experience being described (van Manen, 1997). I came to realise that each perspective provided the "horizon of a particular present, for they represent that beyond which it is impossible to see" (Gadamer, 2013, p. 316). I wondered about the perspective of the other person in the story and found that this wondering surfaced some of the tensions inherent within the story. I struggled interpreting stories initially, nervous about presuming what might be going on between the lines. An example by my supervisor showed a way that was gentle and probing which wondered about possibilities. 'What if, maybe and perhaps', opened the way to other possibilities. I found some of the participant's words stuck with me and I kept them central in my early analysis. These became like favourite items that summed up a feeling that resonated with me. However, I needed to ensure that they were just as important in the data analysis when considering the whole study. Over time as I moved back and forth through the data some faded to have less charm and appeal, while others retained their relevance.

Heidegger described an opening or clearing where the sun shone into the space between the forest trees allowing the play between light and shadow to both reveal and hide what is present (Harman, 2007). So too, was my experience of seeing the meaning that lay within the participant's stories. There were times when reading the stories, I saw paths that appeared promising, only to have them fade away as I moved along them. Other times the path would continue and open to an 'ah ha' moment. One such instance is that I believed I understood the experience of vulnerability in pregnancy since I had experienced this in my own pregnancy and had also discussed such feelings with women for whom I had cared. However, I was surprised when the women's stories revealed the extent of their vulnerability, particularly when selecting a midwife. I realised how much I had underestimated my understanding of this phenomenon.

Determining themes

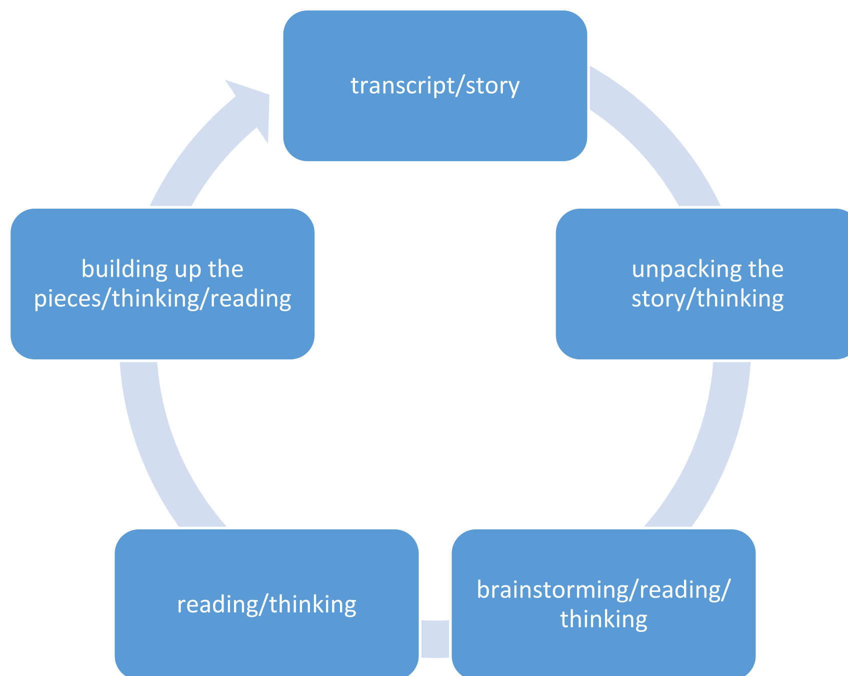
The data were separated into the smaller narratives that made up the participant's story. Some of these were one paragraph long, while others were up to three paragraphs long. I sought to find patterns or themes within the data, placing narratives with similar meaning together. The identification of a theme is not necessarily related to the frequency of its representation within the data. Van Manen (1997, p. 92) states that "a thematic phrase only serves to point at, to allude to, or to hint at, an aspect of the phenomenon". More so, it is the identification of something that matters (Smythe et al, 2008). I printed the stories and cut them up into the specific narratives within the whole story. I laid them across the floor and grouped those which seemed similar, trying out different groupings to find those that felt right. I brainstormed on paper what such groupings meant and where they may lead to. Sometimes these came to a stop early while others proved to have endless possibilities.

I considered whether the way I had grouped the stories into themes resonated with me and whether they captured what the stories said. I posted my research question above my desk and found myself checking back to ensure I remained focused on the intent of the study. Again, I ranged back and forth from the data to readings, particularly those from Heidegger and Gadamer but also beyond, from the sentence to the narrative, to the story and sometimes to the full transcript, and sometimes from my reading to the weeds in my garden. Each view provided a horizon to consider the participant's words. Gadamer (2013), argues that the horizon is being continually reformed as we review our prejudices from the past. This contributes to Gadamer's fusion of horizons, where the data, researcher preconceptions and literature intersect to form new understandings (Koch, 1996). Over time I found that some groupings and stories resonated more with me. The initial groupings related to notions of expectations, professionalism, managing boundaries, and emotion work including trust and vulnerability. These notions varied across the course of the relationship. It seemed logical to have a beginning hence, initiating the relationship became my starting point to tell the stories. This captured the phenomenon in a way that 'felt right'. Such feelings were confirmed in discussions with my supervisors. Sometimes I would get stuck, unable to find a way forward that resonated. At such times discussions with my supervisors were invaluable to find the way. Their questions opened new possibilities.

Focusing the stories

I gave each story a title that described the focus of the story and then grouped them into themes. I found myself getting lost amidst the many stories, sometimes finding I was repeating myself. I wrote up a table showing each theme with the titles underneath, including which participant had shared the story (see Appendix I). This helped me to see a way through. As the themes developed, I found the stories needed reviewing. Not to change the participant's words, but to focus them on the differences and key understandings that each story presented. The stories underwent minimal editing to ensure they were grammatically correct. And again, I returned to the original story and transcript to see if anything else now seemed important and to ensure I had not inadvertently changed the original words. Diagram 1 below sets out to show the circular way I worked with the data.

Diagram 1. The phenomenological approach.



Building the argument

The themes presented themselves to me in a chronological order. All stories start with a beginning and in this study, this began with initiating the relationship. Within the stories, some relationships experienced tensions. While some of these tensions were able to be worked through, others were not, and this affected the participant's experience. All participants had experienced relationships that went well, and that they had enjoyed. The end of the relationship brought a sense of loss to some participants. Finally, I sought to order the stories within each theme to build the argument that would convey my understanding.

Initially I was not confident taking an “insightful leap” from “concrete to abstract” understanding (Miles, Francis, Chapman & Taylor, 2013, p. 412) since it seemed presumptuous to suppose what the participant might be thinking. I found it was one thing to think something, but quite another to write it down. I worried that I may get it wrong. However, as I worked with the data and the message got stronger, my confidence grew in exposing the tensions that sat within the participants words, teasing out what was said and what was not said. I was encouraged by the assertion that the interpretation is mine and that I was privileging that which resonated and mattered to me (Smythe, 2011). Additionally, I acknowledge that I am providing “an opening, a showing, a glimpsing, recognising that there is always more still hidden, still not understood” (Smythe & White, 2017, p. 2).

Conclusion

This chapter has signposted the journey I have followed within my study. I have described how I have engaged with the tradition of phenomenology and how I understand the research question, aims, methodology and methods to be congruent with hermeneutic phenomenology. I have described the back and forth way of working to craft the participant’s stories and to uncover the themes within them, and how I arrived at my understandings. Such description provides the reader with a sense of whether the approach resonates with their understanding of what is deemed scholarly in terms of hermeneutic phenomenology and thus trustworthy. The next four chapters set out the stories from the participants and my interpretation of these towards revealing the phenomenon of the midwife-woman relationship in an Aotearoa New Zealand caseloading context. Themes relating to expectations, vulnerability, managing boundaries, and trust are woven through the findings chapters to describe how these were experienced when beginning the relationship, when there were tensions and when it went well.

Chapter 5: Initiating the relationship

Introduction

Pregnancy has been described as a “transition to the unknown, including meeting one’s life situation, meeting something inevitable and preparing for the unknown” (Lundgren, 2018, p. 81). In the change that lies ahead nothing is certain or can be taken for granted. One of the first steps for women in Aotearoa New Zealand is to find a midwife who can care for her during her journey of childbirth. The woman’s life situation shapes how she anticipates her pregnancy, whether it is welcomed, or not. As well, her life experience influences how she interacts with others. Heidegger suggests that the world reflects our mood (Freeman, 2014). For example, the woman may be confident about pregnancy and birth, and anticipate good relationships, and so her world appears bright and full of possibility. Alternatively, she may be fearful and anxious, and so her world appears concerning. When the woman first contacts a midwife, she brings her experience of ‘mood’ with her and it is likely that this shapes how she approaches and interacts with the midwife. Amidst this complexity of being, the woman must decide whether she has found the ‘right’ midwife and act on that feeling. This chapter describes the experiences of the women and midwives in beginning the relationship.

Finding the midwife

The women in this study reported searching the internet as well as asking family and friends for recommendations when looking for a midwife. Several had accessed the website *Find your midwife,* which provides information about caseloading midwives throughout Aotearoa New Zealand (www.findyourmidwife.co.nz). On the website each midwife has a profile which includes her approach to midwifery practice including the places she provides birth care (home, birth unit or hospital), who her practice partners are, the geographical area that she covers and her availability to provide care for each month. The woman can search for midwives who work near to her and are available around her due date. The website includes information about the New Zealand maternity system and the role of midwives, as well as what to look for in a midwife. In the first instance, the woman must identify a midwife she would like to approach, someone she thinks she would like to care for her. Usually this is through a phone call to ask if they are available in the month the woman is due. However, the first steps in the pregnancy journey is not always so easy. It is likely the woman brings a mood to their search for a midwife, be it one of excitement, angst, or a mix of both. This section explores the experience of looking for a midwife.

The woman has no idea what to do

For Ruth who was in her first pregnancy, contacting an unknown midwife to ask if she can provide care felt challenging.

> *It was a bit daunting at the beginning. I googled local midwives and I also asked friends who had been pregnant. I remember bursting into tears, and I rang my sister and said, 'I have no idea what I'm doing, I don't know what to ask'. She said ring them and say, 'I've just found out I'm pregnant, would you be available to be my midwife'. I didn't even know to ask that (Ruth, woman).*

Looking for a midwife was not straightforward. Neither the information on the internet or the recommendation of friends made the process clear to Ruth. This meant the task of finding a midwife felt overwhelming. Yet the way her sister explained, making the phone call sounded straightforward. Asking an unknown midwife if she could provide care through her pregnancy journey seems to be a vulnerable moment. The woman does not know how the midwife will respond to her, or whether she is even ringing at the 'right' time. Maybe the midwife would be busy, and her call would be seen as intrusive. Further, the woman would not know until she had talked whether this midwife was the one she wanted to care for her. For so many reasons this phone call was important. The unknown of how the conversation would play out makes phoning even harder to do. Making such a call requires a leap of faith that the person on the other end will be responsive to her vulnerability. Where this call was personal for a woman such as Ruth, it is part of the midwife's everyday work.

Frederik Svenaeus (2011) suggests that health is always there in the background, yet rarely noticed until something happens to draw our attention to a change. This everyday way of being is described as homelike-being-in-the-world since the "healthy person feels at home" (Tyreman, 2011). Being homelike relates to more than a physical state of health since it includes how we feel in ourselves. Pregnancy is a normal physiological process, yet there is an otherness as the body undergoes changes throughout the pregnancy journey. Perhaps there is a mix of excitement and anxiety about what lies ahead. Or maybe the woman is filled with fear. Heidegger (1962/2008) suggests that that "in anxiety one feels 'uncanny'" (p. 188). By feeling uncanny he means "not-being-at-home" (Heidegger, 1962/2008, p. 188). Heidegger claims that anxiety is the true state of our being but is hidden from us most of the time (Harman, 2007). Perhaps in becoming pregnant the woman is attuned to changes that occur or that she anticipates in the future, and it is this unknown about herself and her future that can make her world uncanny.

Not knowing what to look for in a midwife

The vulnerability of becoming pregnant requires sensitivity from those who care for her (Leder, 2016). While the attributes of a 'good' midwife can be listed (Borrelli, 2014; Carolan, 2013), it is not always easy for the woman to determine if the midwife has these. While personal qualities may be apparent, the midwife's skills are likely only demonstrated through her actions over time. Further, women may not be sure what is important to them then or in the future. A lack of knowledge about what midwifery entails is not surprising since, in order to provide a protected environment for the woman, most midwifery work is undertaken in private. This means that women often do not know what to expect from midwifery care.

> *When I started looking for a midwife I had no idea about what to look for. I didn't even know what a midwife did. I knew that they deliver because I've seen it on T.V. but I didn't realise what the process was and how involved they are with everything from start to finish. I wanted somebody that I could relate to and work with. It's quite a personal thing and you need to get on with that person (Maisie, woman).*

Maisie was having her first baby and had no prior experience of midwives. Her understanding of what midwives do was taken from what she had seen on television. However, I suggest that what television and film makers determine is good viewing may not be representative of midwifery care. Often birth is sensationalised to add to the drama of the story. For example, the woman's waters break, and she is rushed 'somewhere', usually a hospital. An analysis of reality television shows in the United States found complex birth was overrepresented with women mostly requiring medical intervention (Morris & McInerney, 2010). There are some exceptions such as the television series *Call the Midwife,* which focuses more on the relationships between the midwives and the woman and their families, and with birth scenes that are more representative of reality. The consequence of not knowing what to expect may be that women are fearful of birth due to a skewed perception of the reality of birth and the associated risks. I wonder what assumptions Maisie brought to the relationship and to her birth from her previous understandings.

Despite not knowing what to look for in a midwife, Maisie came with an understanding that getting on with the midwife could be key to how her birth was experienced. It seems that while Maisie assumed the midwife's clinical competence, she did not assume her relational attributes. She wanted to know that she would get on with the midwife. Perhaps someone she could like and respect, someone she could trust. Meeting regularly during the pregnancy provides time for the woman and midwife to come to know each other. Through meeting over time, the woman comes to know if she feels safe with this midwife and whether she can trust her to act in her best interests. The midwife also comes to know what is important to the

woman and this can inform the care she gives. For Maisie, the relationship with the midwife was as important as the midwife's clinical expertise. Thus, being attuned to the woman is a key part of the midwife's role.

Looking for the 'right' one

In being able to choose a midwife, there also comes the possibility of making the 'wrong' choice with its unforeseen consequences. What if the woman does not enjoy being with the midwife, or does not respect her, or does not trust her judgement? It takes time and energy to explore the potentiality that lies in each relationship and searching for the 'right' midwife can be time consuming and exhausting. Furthermore, as the pregnancy progresses the number of available midwives decreases offering less choice for the woman. Finding the 'right' midwife was important to Jo. Yet it was also overwhelming since she did not know what to look for.

> *One of the things I've found the hardest, especially since I'm a particularly confident person, was finding a midwife. I know how to read, and how to plan, and how to evaluate. But it was terrifying and hard, and really there's not a lot of information out there about how to go about it. What to look for outside of where do they birth, what kind of birth do they offer? At the time I was so confused and scared and alone. It is probably the trickiest part because it is such an integral part of the rest of it. It's having that rapport and relationship that you know you've got the right one. It's important to make sure that you are comfortable with your midwife. If you get to a point where things are scary and hard, and you don't feel like your midwife has got your back, then you're in a sticky situation (Jo, woman).*

Usually Jo was a confident person and able to manage the situations she found herself in. Yet in pregnancy she found everything 'uncanny' (Heidegger, 1962/2008). This meant that she did not trust herself to know what to do in this situation. Or at least not in the same way that she usually knew what to do. This was different to her usual decision making since it hinged on how she felt with the midwife. It seemed Jo believed that if the relationship was right, the rest would follow. I can imagine how difficult it must be to know you must make a decision that feels important but at the same time feeling out of your depth. Jo wanted to be able to talk with the midwife, to be comfortable with her and to be able to trust the midwife. 'Having her back' meant that Jo would feel safe because the midwife had expertise to keep her safe and respected her wishes. Such a stance assumes that the midwife values the relationship as much as the woman does. What happens if the midwife is focused on the business of care rather than looking for a relationship that works? I wonder if feeling safe includes having a trusting relationship.

Vulnerability is always with us, but it is often not recognised when our lives are settled (Angel & Vatne, 2016). However, when our boundaries are compromised, such as during pregnancy, awareness of vulnerability is likely to be heightened. During pregnancy women are asked questions about their body functions. They undergo blood tests and ultrasound scans that reveal parts of themselves that are otherwise hidden (Young, 2005). It is a time when women's bodies are brought into the open for review. It is likely that some women feel exposed, while others may be more open to the experience. The woman's response will be influenced by the background she brings including how she feels about being pregnant and becoming a mother, and whether she seeks a warm and open relationship with the midwife. The midwife who is attuned to the woman will likely recognise such struggles and work to understand what is important to the woman. Perhaps in doing so she becomes the 'right' one.

Looking for the right fit

From the beginning the women looked for someone who was warm and friendly and was prepared to take time to talk. Such a midwife was likely to feel 'right'. Heidegger (1962/2008, p. 134) states that the "possibilities of disclosure which belong to cognition reach far too short a way compared with the primordial disclosure belonging to moods". Hence, participants described drawing on how they felt when talking to the midwife, from the first phone call to meeting face to face, to determine if she could be 'right'.

> *I got a feeling about them when I called them. Maybe they weren't friendly or tried to hurry me off the phone. I wasn't keen to settle if I knew that it wasn't going to be a right fit because it was such an important thing to go through with someone. I was relieved to find someone but then once I met her I was also relieved that I liked her, and it was going to be a good fit (Ruth, woman).*

Not all midwives were friendly or prepared to take time to talk with Ruth. Ruth interpreted this to mean that they were unlikely to be the right fit for her. Of course, we do not know what was happening for the midwife when she called. Maybe the midwife was preoccupied with her work, maybe she saw no need to talk with a woman she did not expect to care for. There is no funding for the time midwives spend with women whom they ultimately do not provide care for and this may affect the investment of time the midwife is prepared to make. Because of the midwives' response Ruth did not think they would be 'right' to care for her. Rather she wanted someone who would engage in conversation with her. This would allow her to get a sense of them, and to judge their character and in turn, get a feeling whether a relationship was possible.

It was only after meeting face to face that Ruth knew that the midwife was 'right'. Such knowing is not possible through a tick box exercise that considers skills or qualifications, but rather it is a primordial sense of what feels right. Goleman (2013, p. 98) states that "our circuitry for empathy was designed for face to face moments". Perhaps seeing how the midwife responded to her made the difference. And perhaps in being responsive the midwife became someone Ruth felt she could relate to, maybe someone who could help her to feel more like herself. It may be that once Ruth felt she could trust the midwife, the midwife became likeable and the 'right' one. Perhaps these midwives who were prepared to talk or to meet showed a spirit of generosity that they would engage with her regardless of any payment. Maybe by that action they hinted at the person they were.

Expectations

As described above, women come to their pregnancy journey influenced by their beliefs and attitudes. These understandings may bring a mood of excitement or one of fear, and by doing so, influence their expectations of childbirth. When the woman's expectations are met she is more likely to be satisfied with her birth experience (Fenwick et al, 2015; Bayes, Fenwick & Hauck, 2012). Additionally, the quality of the caregiver-woman relationship and the woman's involvement in decision making contributes to a positive childbirth experience (Hodnett, 2002). Thus, ensuring the woman's expectations are understood and that these are realistic, is an important part of the midwife's role.

When first meeting, the midwife and woman enter a conversation to come to an understanding of how they will work together. While both the midwife and the woman may enter the conversation with information they wish to share or find out, neither knows what will arise from their conversation (Gadamer, 2013). In seeking to gain an understanding, both the woman and the midwife are likely to be alert to cues from each other and this will inform their responses. How the relationship develops will be informed by how each has experienced relationships in the past. The midwife also brings expectations based on her own philosophy, professional guidelines, and requirements of how she can work with the woman to provide care. These factors contribute to making each midwife-woman relationship unique. This section explores the expectations that women and midwives bring to the relationship.

The midwife sets her boundaries

The beginning of the relationship is a time when the midwife explains her ways of working and underlying philosophy of practice to the woman. In turn, the woman shares her knowledge and understandings of birth (Guilliland & Pairman, 2010a). The sharing of information is an important part of the partnership with both partners bringing their own expertise to negotiate informed choice (New Zealand College of Midwives, 2015). The first meeting provides the woman and the midwife with a sense of each other and for some, this will determine if they wish to proceed with the relationship. At the end of the meeting either could decline to work with the other based on a 'feeling' of how well they could work together. This first meeting can be a time of testing out the relationship and being reassured, or not, by the responses received.

> *It was the woman's fourth baby and she knew what she wanted. She said, 'I know what works for me. I'm not going overdue and you're going to stretch me at 37 weeks'. I said 'If you can show me the research and I feel comfortable doing it, sure. But I'm not going to do anything that I don't think is right. It's my job to give you both sides of the story and you get to make the decisions. But I'm not going to do something that doesn't sit comfortably with me'. She said, 'oh yeah we'll work'. I thought okay, I passed some test (Kelly, midwife).*

Managing expectations is an important part of the midwife-woman relationship. The woman did not want to go overdue and came with a plan that she believed would work for her. Perhaps anxiety drove her understanding of what would be right. But there was something ahead in her pregnancy, likely something learnt from her previous experiences that she wanted to avoid this time. It seems that Kelly's refusal to implement the woman's plan without any sound evidence was reassuring for this woman. In stating her stance, Kelly was expressing her commitment to keep this woman and her baby safe by drawing on evidence to do so, and in a way that included the woman in any decision making. In laying out her expectations the woman may have sought to provoke a response from Kelly that would help her to determine whether this was the 'right' midwife for her. It seems that Kelly's response reassured her that they could work together.

As the health professional, the midwife has the professional responsibility for ensuring the woman has realistic expectations and makes informed decisions about her care (Guilliland & Pairman, 2010a). Failure to do so may be viewed as an abdication of the midwife's professional responsibility. The Code of Health and Disability Services Consumers' Rights (the Code) describes the rights of consumers of health services, and the responsibilities of the service providers (HDC, 1996). These include the right to be fully informed and to make an informed choice. In this story Kelly was reassured that the woman listened and accepted

her guidance. I wonder how the relationship would have developed had the woman not been receptive to her advice. Within the midwife-woman relationship, it is usually the woman who chooses whether to continue with the relationship and not the midwife. Thus, it is the midwife who sets the scene and the woman who accepts and stays or chooses to look elsewhere for midwifery care.

Feeling a connection matters

The beginning of the relationship is a time for making judgements as to whether the relationship feels 'right'. Tickle-Degnen and Rosenthal (1990, p. 286) suggest that connection is evident when there is "mutual attentiveness", "positivity" and "coordination between the participants". When neither know each other there can be some awkwardness and this brings a risk of misunderstanding (Tickle-Degnen & Rosenthal, 1990). Each is watching the other for cues as to how this relationship will develop. In the back and forth of conversation each participant's mood is revealed. Feeling connected with others is linked with health and longevity, while the absence of connection is linked to risks for our wellbeing (Holt-Lunstad, 2018). It is within relationships that we learn how to interact with others and to make sense of our world. Our relationships also influence how we feel about ourselves. This means that we seek social connections in a way that is meaningful to us. It is not surprising then that women seek to feel a connection with the midwife who is caring for them.

> *The first midwife was very business-like and there was no other conversation around anything other than what we were there for. She didn't do anything wrong, it's just I wanted the conversation to flow. There was no emotion and she didn't connect with me in that first instance. It was more structured and ticking the boxes. This is what I need to talk to you about. This is how I work. There's a lot of fluffiness with me in that I want to know I am in safe hands and that there is time for conversation. I figured I was going to them for 9 months or so, and I wanted to enjoy seeing them and get to know them. Midwives are a little like counsellors at times. I would talk to her about lots of different stuff in my life (Jane, woman).*

Jane expected to feel a connection with the midwife. However, the midwife did not respond to her as she expected and this left Jane feeling that the midwife was not attentive to her needs. When a sense of rapport was not revealed, the midwife did not feel 'right' for her. Jane had anticipated a warm relationship with her midwife but instead, she felt the midwife focused on a 'script' of things to complete. Jane expected the midwife to share some of herself. When the midwife did not, she was acutely aware of the absence of the emotion she expected to experience. She wanted the midwife to see her as a person, rather than another pregnant woman and she did not feel that was happening. To Jane being cared for included the midwife sharing something of herself from the beginning of the relationship, of opening

up a conversation that could run its own course. The first meeting sets the scene for how the relationship may unfold. This midwife did not do anything 'wrong', yet Jane did not have confidence that the relationship would develop in a way that she had expected. It may be that an absence of connection is experienced as mistrust.

Howarth, Swain & Treharne (2012, p. 492) suggest that the absence of "a warm and caring relationship" between the woman and those who care for her means that women are more likely to feel vulnerable and anxious and to feel less satisfied with their birth experience. It seems this midwife was focused on documentation and compliance that is required for care that is deemed 'safe'. But in doing so she did not attune to what was important for Jane. It may be she was distracted with other things, perhaps the needs of other women in her care. This story shows how easily the midwife can get it 'wrong'. The consequence is that the woman may look for care elsewhere as Jane did. I wonder if they had continued how the relationship may have developed. Would the midwife have become more conversational as this woman sought? Or would the woman have come across to the midwife as 'needy' and anxious? Or perhaps as someone who asked too many questions? It seems that attuning to the woman and what is important to her is part of her feeling safe.

The midwife looks for some sort of connection

Midwives also look for a connection in their relationships with women.

> *After I determine we are on the same page the other thing I look for is that there is some sort of connection. I guess if we don't manage a laugh in that first visit, I'm not so excited about seeing her five weeks later (Kelly, midwife).*

Kelly wanted to know that what was important to her was also important to this woman. Alignment of their goals was key, but sharing a connection was also important. Being able to share in conversation and laugh together suggests being at ease with each other. Freeman (2014, p. 463) states that "moods are disclosive of the broader context of one's existence in the world and can reveal to us things that beliefs cannot". Therefore, how the woman engaged suggested to Kelly how the relationship may play out, whether this might be an easy relationship, or not. Midwifery care is personal and at times intimate and so I suggest it is easier to provide and receive such care if you have positive regard toward the other person. Without a connection it may be harder for the midwife to provide care that feels authentic. While the midwife has a professional responsibility for the care she provides, I wonder what this midwife would have done had they not shared the same goals. This suggests that it is usually the woman who determines whether she wishes to pursue the

relationship and ask the midwife to care for her. Thus, the woman has a strong influence on how the relationship plays out.

The midwife's experience and approach to birth matters

Women come to the relationship with understandings about what matters. Stories of pregnancy and birth are shared via family and friends, from other health professionals and from an increasingly global community. The stories that the woman hears will inform her expectations of her pregnancy journey and of midwifery care. What 'they' say informs her understanding of what is important. Jane drew on recommendations from those around her to help her determine what attributes she should look for in a midwife.

> *I wanted a mother figure meets personal trainer. Someone who could hug me but also tell me to just do it because I was capable of it. I wanted a midwife who had a nursing background and had been a midwife for a long time. If my natural approach for a birth had not gone as planned, then I wanted my midwife to support me in the hospital environment. You hear horror stories as soon as you're pregnant. I wanted to know that I could have drugs if I wanted to and I had heard that the only way to have drugs was by going to hospital, so I wanted that as an option (Jane, woman).*

Jane wanted a natural birth, but she wanted a plan B just in case. She sought an experienced midwife, someone who would be with her no matter what happened and no matter where she birthed. Someone who would be kind and nurturing, who would look out for her best interests and if need be, push her to achieve her goal of a natural birth. Her plan B meant she might need help, and if this included drugs and hospital care she wanted her midwife there with her. I am not sure why a nursing background was important. Perhaps 'they' had told her that hospital care was accessible through a midwife who was also a trained nurse. However, almost 59% of the midwifery workforce have a direct entry degree in midwifery as their qualification and these midwives work in our hospitals (Midwifery Council, 2020). It takes time to change some understandings.

Some of the stories 'they' had told Jane frightened her. These included difficulties accessing medication when the woman wanted it, or the midwife leaving the woman if she went to hospital. 'They' suggested that with the right midwife there would be no difficulties. In Aotearoa New Zealand women who are well may choose to birth at home or in a midwife-led birthing unit, however if complications arise she will likely move to a hospital. The woman is likely to feel vulnerable when she moves to hospital. She is often tired and facing uncertainty about what may happen next. She does not know the midwifery or medical staff. As well, my experience suggests that her midwife is likely to be weary. Within the current maternity

system caseloading midwives may hand over care to hospital-based midwives when complexity arises, in part due to inadequate funding for midwifery care of women who experience prolonged labours. While the woman is unlikely to want a tired and potentially unsafe midwife, having someone who knows her at such a vulnerable time is important.

Feeling cared for matters

The midwife's responsibilities are laid out in contractual terms (Ministry of Health, 2007) and through guidance documents (Ministry of Health, 2012; New Zealand College of Midwives Consensus statements, varied dates). However, the quality of the relationship is important to the notion of feeling cared for (Hunter et al, 2008). Authentic caring occurs when the woman feels that what happens to her is also important to the midwife.

> *She was experienced so that made me think she would manage if anything happened. She had this air of confidence about her without being too cocky. She was more 'mother bear' than 'head mistress'. She wasn't intimidating but she cared, and she wanted to look after me and my baby. I might not have got that in someone who was my age or younger (Stella, woman).*

Everything about this midwife reassured Stella. She had years of experience to draw on. To Stella, being older than her gave the midwife greater credibility and authority. She exuded confidence but was careful of her limitations. But it was her manner of being with that reassured her that what mattered to her also mattered to this midwife. This meant she believed that the midwife would be 'there' when she needed her, and that she would advocate for her if needed. Of course, this did not mean that the midwife was always present. Rather, all would be well because the midwife had made it so by 'leaping ahead' (Heidegger, 1962/2008), and by doing so everything would be manageable. Such care is concerned with supporting the woman to uncover her own knowing (King, 2001). Like Jane's story before, Stella sought someone who would protect her and advocate for her, rather than someone who dictated terms. It seems to me that Stella felt cocooned by this midwife. Perhaps supported and protected along the way.

Listening matters

What we say does not necessarily convey the intent of what we mean. While we have a wide range of language, these can "miss the fullness and the uniqueness of our private worlds" to enable us to fully describe our experiences (van Manen, 1997, p. xiii). Additionally, how we experience something is dependent on how we see the world. For the woman who is anxious, everything may look challenging and of concern (Freeman, 2014). It takes time to

build the professional relationship and to explore the understandings that women bring to their childbearing journey. However, in doing so, the woman is likely to feel the midwife understands what is important to her and can be trusted to care for her.

> *I expected I would always feel listened to and that the midwife would always have the time to listen to things, even if they didn't seem important, because they were important to me. I wanted someone who didn't dominate the space or the conversation. Someone who sat back and asked questions and listened, so I felt like the control was in my hands. I expected she would always let me know if she thought something's not quite right. You share enough that they get to know you and what's important for you (Milly, woman).*

Milly expected the midwife to listen to her and in doing so, come to understand what was important to her. To listen to her was to take time even if it didn't seem important. It meant to ask questions and to show the possibilities that lay ahead so that any choices remained with the woman. It meant being compassionate and non-judgemental. It meant showing that what was important to Milly was also important to this midwife. It seemed that it also included the midwife taking a back seat while Milly was firmly in the driving seat. But while she was happy to determine their direction of travel, Milly trusted that the midwife would keep her safe should anything untoward arise. Such attributes showed that this midwife cared.

Reaching an understanding of what is important to her requires the woman to be open to sharing her thoughts and feelings, and the midwife to have time to listen. It is likely that this sharing occurs over the course of the pregnancy as they get to know each other. Such ways of being with the woman align with professional expectations of midwifery care. In Aotearoa New Zealand, the length of midwifery appointments is determined by the midwife. Anecdotally, midwives describe appointment times of between 20 minutes to one hour. It may be that women who are open to sharing and who want time to talk choose a midwife who can give them the time they need. I wonder what happens if the midwife appears too busy to listen or is distracted by her other responsibilities. I suspect there are women who feel there is insufficient time to share of themselves in the appointment time offered by the midwife. Perhaps they 'make do' within the relationship they have. Or perhaps they come across to the midwife as 'needy'.

Feeling safe matters

The International Confederation of Midwives (ICM, 2014) describes the knowledge, skills, and ways of behaving of midwives. Within Aotearoa New Zealand, the Midwifery Council prescribes the competencies that midwives must meet, and the College of Midwives

provides professional guidance and support to midwives. These criteria aim to facilitate a safe birth for the woman and her baby. However, feeling safe is a complex phenomenon.

> *I wanted someone who could think fast and have the knowledge and experience to make a good decision if things didn't go well. Someone who was confident and knew what they were doing to make the best decision in the moment. You're trusting them to make a decision for you when you aren't able to or when you don't know what the best thing is. It was important that I felt comfortable with her and that she accepted the way I wanted to do things (Amy, woman).*

The 'right' midwife makes good clinical decisions that are right for the woman and in a timely way, and in doing so help her to feel safe. But from Amy's perspective, the midwife could only know what was right for her, by taking time to understand what was important for her. And Amy could only share what was important for her if she felt comfortable talking with the midwife, for it was only through talking together that they could understand each other's perspective. Talking together would also reveal the character of the midwife and this would indicate whether she reassured Amy, or not. It seems the pregnancy can be a bit like one long interview where the woman comes to know whether the midwife is 'right'. Yet as the relationship progresses it may be the midwife becomes 'right' because the midwife is open to understanding the woman.

It is likely that Amy assumed clinical competence when first meeting the midwife, and so looked for relational attributes such as confidence and someone she felt comfortable being-with, to reassure her that this was the 'right' midwife for her. As she progressed through the pregnancy journey Amy would be reassured, or not, that the midwife had the skills she expected the midwife to have. Things such as knowing how to navigate the dangers that might arise and being able to guide her through her childbirth experience safely. Someone she could trust to look after her at a time when she was vulnerable. Someone who was open to her how she wanted to do things. Feeling listened to is part of feeling safe (Smythe, 2010). The 'right' midwife would trust her to know what was right for her and in turn she could trust the midwife.

I need her focused on me and baby

Women come to the relationship with assumptions and expectations about the sort of relationships that they prefer to engage with. Perhaps ones that are close, or not. The beginning of the relationship is a time to explore these expectations and manage any that do not fit with the other's way of being.

At the beginning, I wondered if it was the best fit. I'm often drawn to people who are sharers and probably extroverts who will talk and chat and are friendly. That was who I thought I would want. Someone that would give me a hug when I got upset. Once I was going through the process, I realised that's not what I needed. I've got family and friends for that. I thought, I don't need someone to be my best friend or to talk to me about everything else. I need her to be focussed on me and the baby. That's why I thought she was the perfect fit (Ruth, woman).

Initially the relationship did not feel quite right to Ruth. The midwife was different to people she usually had relationships with. Despite her doubts about their fit, Ruth remained in the relationship. As she got to know the midwife better, she reviewed her assumptions about the midwife's role in her care. Rather than the midwife taking over from her friends and family, Ruth realised that the midwife was an addition to her network, albeit in a professional role. While it was a close relationship, it was different to the usual relationships she had experienced. Perhaps she adjusted her expectations. Maybe she found that their shared goal was sufficient to ensure a successful relationship. Either way she came to realise that this midwife was 'right' after all.

The beginning of the relationship can be a time of adjustment. Both come with their own understandings and ways of being. This means there may be a risk of misunderstanding the other's intent, thereby setting the relationship on a pathway that one or both may not enjoy. If women have limited choice in finding another midwife, then the onus may be on the woman to adjust to the midwife's ways of working. However, by engaging in conversation they can reach an understanding regarding their relationship and ways of working. I suggest that the woman is likely to adapt since it is she who needs care, while the midwife can walk away. However, one or both may adjust their expectations of the other person or of the relationship if they are committed to making it work. This may be done explicitly and implicitly as both learn what is important to the other. Perhaps that is how Ruth came to see this midwife who was focused on caring for her and her baby, was a good fit.

The midwife looks for a relationship

Being able to truly care about the woman can be challenging for the midwife. Things such as ongoing workforce shortages, the focus on policy and processes, and difficult relationships with some women may create tensions in being able to care in a way that feels authentic to the midwife. However, when the woman engages in the relationship it seems that caring becomes easier for the midwife. Hence, while the intent of the relationship is to meet the

woman's needs, the midwife also looks for a relationship with the woman, although this may only be evident as the relationship progresses.

> *I think honesty is important in a good relationship. The ability to express yourself no matter what. Mutual respect, trust and openness are important too. You share a bit of yourself and I'll share my midwifery knowledge and together the journey will be easier. I like having a bit of fun as well. I think I get more from people that I engage with. When I don't feel the relationship is working I don't share much of myself (Judy, midwife).*

Conversation opens the way to a relationship that 'works'. It was in the back and forth of conversation that Judy could get a sense of how the relationship may play out. Whether the woman was open to sharing or not influenced her understanding of how much she could trust the woman. In the absence of mutual trust and respect she found it difficult to be as open with the woman. Perhaps in such relationships she had to consider each conversation, each action to ensure the woman agreed with her. In sharing some of herself the midwife is vulnerable as to how that information will be received and whether it will be respected by the woman. Such relationships may feel like hard work with spontaneity missing. When the midwife and woman are out of tune, it is harder to reach a shared understanding or to create a trusting relationship. Not all women seek "emotionally connected" midwifery care (Hunter, 2006, p. 320), and this means there are times when the midwife must 'fit' in with the woman to meet her needs. This suggests that it is the woman who determines how close the relationship gets.

The midwife must determine how much to share, in what circumstances, and to consider how the woman might understand her intent. This cannot be prescribed but must be sensed by the midwife to determine what is 'right'. Once personal information is shared it is not possible to take it back. It cannot be unknown by the woman and it becomes hers to use as she wishes. There is a professional expectation to maintain a distance and to ensure that every interaction has the benefit of the woman in mind. Yet in sharing a part of herself, Judy sought to build rapport with the woman. The sharing of appropriate and timely intimate information signals to the woman that she is trusted, and it is likely that this deepens their relationship. I am reminded that "trust eases the way to co-operative social relations" (Hardin, 2002, p. 173).

Making the commitment

In Aotearoa New Zealand it is the woman who looks for the midwife, the woman who determines if the midwife is 'right', and it is the woman who commits to entering the relationship with the midwife. This assumes that she has a choice and if so, that she exercises that choice. The stories women shared revealed their vulnerability in looking for a midwife and determining if she was 'right'. I can only imagine the woman's relief in finding someone who seems to be 'right'. Of course, this is not to say that the midwife is passive in initiating the relationship, or withdrawing from it. But for the woman this is her journey and it is the midwife who travels alongside her. This section explores the experience of the relationship that feels 'right'.

The decision feels urgent for the woman

The Ministry of Health advises women to find a lead maternity carer, most of whom are midwives, as early as possible in their pregnancy. This has physical benefits of establishing a plan of care and identifying any underlying concerns, but it also allows the woman to establish the relationship with the person who will be caring for her. Jane wanted to find the midwife who would care for her, however, not all of the midwives she contacted shared her enthusiasm to meet so soon in her pregnancy.

> *At the beginning, I was in a rush to get things moving. My first thought was, get a midwife and she'll guide you. But some midwives wouldn't see me until I was ten weeks. I was a first-time mum and I wanted to know how far along I was, and I didn't know what I needed to do. I was excited, and I wanted the answers quickly. I met the first midwife and she said, you can sign up today or you can have a think about it. I felt a bit flustered and like I needed to decide then because I was in the room and the paperwork was out. I wanted to get the ball rolling, so I signed up. I left feeling a bit uneasy and feeling like I'm not sure if this is right, but it might grow and develop a relationship (Jane, woman).*

Jane was excited to be pregnant and had so many things she wanted to find out about. This was her first pregnancy and she believed it was the midwife who would guide her and who could answer her questions. The longer she waited the longer she did not know. Perhaps the midwives she contacted hesitated because they were unwilling to commit to a relationship 'too soon'. Perhaps they worried about the risk of miscarriage. Perhaps their previous experience was that women who rang when they were only just pregnant could be 'hard work'. Waiting for the midwife to be ready was not an option for Jane and so she kept looking for someone who was prepared to meet her 'now'. Perhaps she sensed that the midwife who would not meet her 'now' was not attuned to what was important to her. This midwife offered to meet with Jane, but then moved on to 'sign her up'. This put Jane in an

awkward position as she was not sure but did not know how to get out of the situation gracefully. She hoped that the relationship she wanted would develop. Of course, she could always change midwife but that is not always easy since she would then need to tell this midwife she no longer wanted her care.

Phone conversations only tell us so much about the other person. Meeting in person would confirm that this midwife was 'right'. If the midwife she had chosen over the phone turned out to be 'wrong', she would need to start her search again. Remember Maisie's story where it was only when meeting face to face that she knew this midwife was 'right'. Midwives book a specific number of women each month and then stop accepting women for care. Searching later in her pregnancy would likely have meant her choice of midwife was limited to those who were still available. If that occurred she might need to accept a midwife who was 'good enough'. There are situations where women do not engage with their pregnancy out of concern for miscarriage (Priday, 2018). However, health professionals are expected to provide early pregnancy care. It is interesting to note that in 1975 women were advised to seek maternity care soon after missing their first period (Myles, 1975), so perhaps at around six weeks gestation. More recently, the NICE guidelines recommend the first visit to occur by ten weeks (NICE, 2017). It seems that while health professionals have delayed the commencement of pregnancy care this does not suit all women.

It is not easy to say "No"

When the woman has met more than one midwife, she must choose which one she wants to care for her and tell the others that she does not want their care. Even at this early stage, it can be difficult to end the relationship.

> *I found it awkward after I'd met one midwife to tell her no, even though she was lovely. You feel awful. We got on really well so I'm not rejecting her for any reason. It's just that I found somebody that I worked better with (Maisie, woman).*

Making value judgements can be uncomfortable. Maisie enjoyed meeting with the midwives. They were friendly and gave time to talk with her. But to Maisie, one stood out over the other as someone she felt more comfortable with. Value judgements are an intuitive process that draw on expectations, understandings, and emotions to determine what is a best fit. Maisie worried about hurting the midwife's feelings by telling her she did not wish to proceed with her care. Perhaps she worried that the midwife might ask her why. It is likely she would not be able to explain her decision and that would have made it even harder. How do you explain a feeling of what is right? It is interesting that even at this early stage it is not

necessarily easy to get out of the relationship. It is likely to become only harder as the relationship progresses.

Conclusion

This chapter reveals the vulnerability the woman experienced when beginning her pregnancy. For some, her world became uncanny, and there were times when she struggled to recognise the person she had become. This contributed to feeling somewhat overwhelmed by the process of finding a midwife to provide care. To ease her way, the women sought a recommendation from someone she trusted. Finding the 'right' midwife was seen to be important to the success of her pregnancy and birth experience. It was in the back and forth of the conversations that the 'right' midwife was revealed. The 'right' midwife had relational attributes and was responsive to the woman's needs. She could see the woman as a person and was willing to invest in their relationship. She cared about what happened to the woman and had the skills to keep her safe. When the midwife demonstrated such attributes, she became likeable to the woman and felt 'right'. In turn, the woman could trust that the midwife would support her at a time when she was vulnerable.

Midwives', in contrast, demonstrate a responsibility of care. Even though they may discern in the first visit that the relationship may not be easy, they are less able to decline to proceed with the commitment. However, if there is evidence that the woman may not listen and heed their guidance as to what is safe practice, they may then recommend the woman look for another midwife. There is an assumption that both partners know the relationship matters. Putting energy into making the relationship work may be left to either the midwife or the woman. Likewise, sometimes it was the midwife who dominated the relationship, while at other times it was the woman. It seems that even a relationship that feels 'right' at the first meeting is open to challenges and possibilities as the pregnancy progresses. The next chapter will explore working with boundaries.

Chapter 6 - Working with boundaries

Introduction

Midwives in Aotearoa New Zealand work under legislation which provides a regulatory framework that "focuses on public safety to ensure a competent and safe midwifery workforce" (Pairman & Gray, 2019, p. 218). Professional frameworks complement this by "setting philosophy, standards of practice, and ethics and practice guidelines that members are expected to follow" (Pairman & Gray, 2019, p. 218). As well as the regulatory and professional frameworks to guide their practice, midwives as health professionals must draw on their own judgement and decision making when providing care (Higgs, 2014). These boundaries and frameworks support the midwife to provide care that is individualised to the woman and which seeks to keep her and her baby safe including situations that are complex. In some circumstances, the midwife will be stretched to capacity or even beyond that which is familiar. While boundaries provide guidance, they must also be flexible to enable the midwife to respond authentically to the situations that are encountered. New Zealand midwives have come to recognise the importance of being clear about their own specific boundaries to protect personal space. Communicating these boundaries requires a delicate touch. If the midwife does it too soon in the relationship she may be seen as business-like and less relational. On the other hand, if it is later in the relationship, boundaries may already have been inadvertently breached or falsely assumed, potentially leading to unsafe situations. Timing is everything. This chapter explores the experience of working with boundaries considering setting and maintaining boundaries. It also explores when boundaries may become blurred in response to knowing each other.

Setting boundaries

The Ministry of Health (2007, p. 1060) contracts the caseloading midwife or her backup, to be "available 24 hours a day, 7 days a week to provide phone advice to the woman, and community or hospital-based assessment for urgent problems, other than acute emergencies". The onus is on the woman to determine what is urgent. Midwives usually provide planned antenatal and postnatal care during the week within office hours, while remaining on call at nights and weekends to respond to events that are urgent or deemed urgent by the woman. Midwives work in partnership with another midwife or group of midwives who provide backup cover for time-off. However, how often they are used is not prescribed. This means that time-off is determined by the midwives in the practice and varies depending on what suits the practice and what back-up support is available. There are many variations of how this occurs. For example, the midwife may have alternate weekends off or

they may work alternate week on call and week off call, they may pay each other for work done or regard such support as part of their relationship. Much will depend on the size of their caseload and their relationship. Providing continuity of care has the potential to impact on the midwife's well-being, with possible burnout (Donald, Smythe & McAra-Couper, 2014). Thus, the on-call midwife will likely set boundaries as one of her strategies to support sustainable midwifery practice. This section explores the experience of the midwife setting boundaries and how the woman understands them.

Being explicit

When the midwife first meets the woman, she will usually make her ways of working clear, including when and how to contact her. For Deb setting boundaries was part of setting up the relationship with the woman. Perhaps she had learnt there was a need to be so explicit.

> *I'm very clear on instructions and I write them down. I say 'I am on call 24 hours 7 days a week, so you need to respect my time. I have work hours and emergency hours. I am on call for emergencies 24/7 but I am not at work 24/7. If you contact me out of hours for something that's not urgent, I am likely to send my rejection text. It says you've reached me out of hours, please call me between the hours of 8 and 6 unless it's urgent'. They laugh. I try and make it funny, so they'll remember it (Deb, midwife).*

Providing clear instructions was important for Deb. They protected her own time and made the woman aware of her availability. In making her expectations explicit she also called on the woman to respect her own time, perhaps revealing herself as a person who had family commitments. Of course, the midwife's instructions cannot cover every possibility and so it seems inevitable that there are times when the woman may get it 'wrong'. Heidegger (1962/2008, p. 122) states that "everyday Being-with-another maintains itself between the two extremes of positive solicitude – that which leaps in and dominates, and that which leaps forth and liberates". Deb sought to leap ahead and ensure the woman knew how and when to contact her. If their understandings aligned, then they would come together when it mattered to both. The reality of working on call for long periods means that midwives look for ways to protect their time. When the woman gets it 'right', it is likely that the midwife is more able to manage the on-call nature of her work. Perhaps Deb had learnt there was a need to protect herself.

In leaping ahead, Deb forewarned the woman about her 'rejection text', thus alerting the woman to the possibility she might get it 'wrong'. However, with each text she receives the midwife must make a judgement as to whether the situation is urgent or perhaps something

she should investigate further. Working on call requires the midwife to remain vigilant and ready to respond at all times. This assumes the woman will clearly communicate her concern and will contact the midwife again if anything changes or she is unsure about the midwife's response. These instructions provide the midwife with a way to survive in an environment where she is continually on call for the woman who may call if she is concerned or unwell, or perhaps has a situation she is worried about. Such ways of working assume the woman is usually well and will respect the midwife's own time. But what about the woman who is unsure if her concerns are serious, or who worries about disturbing the midwife unnecessarily? These ways of working call upon a relationship where the midwife is generous with her time and the woman (and perhaps her family) is thoughtful before calling.

The woman trying to figure it out

Pregnancy and birth are part of the midwife's everyday work; however, it is not part of the woman's everyday world. This means that understanding the midwife's expectations is not always straightforward for the woman.

> *My midwife was specific about when to contact her and it took me a while to grasp when to text or when to call. Sometimes I was a little hesitant to call her so I'd just text. She always got back to me which was good. I was trying to figure out when I could call her knowing that she had other ladies she was looking after, or if she was in a birth I didn't want to bother her. I felt I could contact her, it was just trying to figure out what was appropriate. I'd go to appointments with her with a list of questions and I felt like I could always ask anything, and she'd help. I've learned that when having babies, pick one or two people and trust what their opinions are and block out everyone else (Ruth, woman).*

Ruth wanted to do the 'right' thing. She had received specific instructions, yet the reality of what to do in the moment was not so clear. She was 'there' with her concern. Should she ring or should she text? She did not want to risk being a nuisance by contacting the midwife in a way that was not 'right'. Nor did she know what the midwife was doing and what her call may intrude upon. Ruth regarded ringing as more intrusive than sending a text. After all, a text may be viewed at a time that suits the midwife, whereas a phone call demands immediate attention. Yet there is a risk that a text message is not seen or is misunderstood, if indeed it is for something urgent. Ruth trusted that the midwife would understand what was happening for her in that moment and would contact her when it was appropriate. Because the midwife always got back to her, Ruth learnt to trust she was 'there' for her. Being-with-another is more than being physically alongside. When the midwife knows the woman, she can respond in a way that acknowledges what is important for that woman and which reassures her that the midwife is 'there' for her, even if this means later. In this way the

midwife was available to support the woman while also caring for herself. Communicating boundaries is more complex than simply giving a list of instructions.

The onus is on the woman to get it right. The midwifery partnership sets out to provide a framework for a relationship with the woman bringing her "intuition, intrinsic wisdom, self-knowledge and experience" to the partnership (Guilliland & Pairman, 2010a, p. 42). Yet for the woman, her self-knowledge may feel uncanny (Heidegger, 1962/2008) in the face of the physical and emotional changes she is experiencing. Instead, she may look to the midwife for reassurance that all is well. The risk for the midwife is that the woman hesitates to phone her when there is a problem that requires urgent attention. The risk for the woman is in getting it wrong, either by calling or by not calling. Perhaps the quality of their relationship will influence whether the woman feels she can call, even if this might be 'wrong'. Interpreting boundaries in a particular situation is never straight forward.

Struggling with setting boundaries

Setting boundaries requires the midwife to consider her own needs and how these will be met, while also ensuring she meets her professional and regulatory responsibilities. As the health professional, the midwife is responsible for her own wellbeing. However, this can be in tension with the concept of a woman-centred profession where the "midwife's focus is on the woman" (Guilliland & Pairman, 2010a, p. 38).

> *As a new graduate the things that I thought I would struggle with were not what I actually struggled with. I struggled with the boundaries around my women, the texts, the phone call out of hours that were not emergencies kind of stuff. You think you know but you have no idea until you're in it. I developed boundaries and made a safe working environment for me. I want them to feel that they can ring me if they are worried but also to use some common sense in that. Which is tricky (Clare, midwife).*

Some aspects of being on call can be hard to prepare for. Despite feeling prepared for caseloading practice, this midwife was surprised to find herself feeling overwhelmed. The women she worked with wanted more of her than she felt able to give, or perhaps was realistic. The public parameters suggest huge availability of the midwife, which then requires the midwife to manage the woman's expectations to ensure these are more realistic. When autonomy was gained the profession set out their expected ways of working, and this included being available. What was not realised was that some women would not take up this offer responsibly. The midwifery partnership is based on a mutually respectful relationship. However, the reality is that some women are frightened, or it seems the midwife

is the only person to support them, maybe if their family are overseas or they are alone. In those situations, the midwife can be called upon to become the woman's support person as well as her midwife. Such relationships can be difficult to sustain.

Being on call means knowing that at any time the phone could ring. The dilemma for the midwife is how to maintain a closeness and availability with the woman while also protecting her own space. Space considers not just the physical space around the midwife, but also her felt space. That is, something can feel close without necessarily being physically close. Van Manen (1997, p. 102) describes 'how we feel in a given space' as "felt space". Ordinarily our home is somewhere secure "where we can feel protected and by ourselves" (van Manen, 1997, p. 102). Yet what happens if the midwife feels she has lost her own space? What if the woman follows her into her home? Not literally of course, but in the sense that the woman intrudes on her family time with issues that could easily have waited. Of course, there are times when a midwife needs to be concerned and thinking about a woman she is caring for. Letting go of the ever-present-ness of women in her caseload is something that midwives learn to manage. As a new graduate midwife, Clare was also experiencing the accountability and responsibility that midwives take on in providing care for women. Midwives learn to manage this but there are times when the weight of responsibility can be heavy.

The midwife protects personal boundaries

Another issue that midwives may experience is when their personal and professional lives overlap, particularly when they live and work in smaller communities. As a public persona the midwife may feel she is always 'there' to care for others and that she is 'on show'.

> *Some women will say to me, how was your weekend away and I'm like how did you know? My Facebook is private, but your friends might have a picture of you doing something and because it's such a small community, they all see it. One of my clients plays squash with me. In a way that's nice. I try not to talk to them about their babies when I see them out. Unless women ask, I won't offer any personal information. Sometimes I have the odd story of my kids but generally, they wouldn't know anything about me unless they asked. And then I'm a bit vague. I guess it's a trust thing. Are they a normal person? Are they going to share this? What's their friend network? I don't know how I've decided, I just have. It's probably a security thing and they didn't come to hear my story about my weekend. You make a decision about what you share. They don't get a lot out of me. I don't get told I'm not warm and friendly, so I guess it's a balance (Kelly, midwife).*

As a midwife in a small community, Kelly's personal life intersected with her professional life. That worked if the women she cared for could be trusted to respect her privacy. But she was

not sure that all women would. Keeping control of her personal activities was one way to protect herself from unwanted attention. Maybe she felt watched with her every move scrutinised by some in her community. No wonder then that she was careful about what she shared of herself. Kelly was clear that the professional relationship was not about what she did at the weekend, or about her life. But she also cared for some women from within her community who were a part of her private life. It is clear that managing boundaries in such settings is not straightforward. While there are professional guidelines for how midwives work with the woman's information, there are few restrictions on what the woman may do with stories of the midwife's life. The sustainability of rural practice rests on the relationships the practitioner has with their community, and that community's trust and confidence in the service (Crowther & Smythe, 2016). Anecdotally, rural midwives describe challenges when women share their negative experience with others in the community. Perhaps this midwife was aware of how her standing could be undermined and sought to protect herself.

The midwife is careful not to make it about 'her'

There are times when sharing builds rapport, and other times when sharing may risk the relationship. How much to share is a balancing act.

> *I usually tell women that I've got a couple of kids. It depends who it is. I tell people I'm married. I'll share snippets of birth stuff like if a woman's breastfeeding has gone belly up and they're feeling really bad about it, I'll say you're not a terrible mother. I was devastated when it happened that I couldn't breastfeed my first child. I had all the support in the world. I say I have these two healthy adult children. I do think you have to be very careful not to make it about you (Rose, midwife).*

Rose was careful about what she shared. If it felt right, she might share something personal like her own breastfeeding experience. But her intent was that what she shared should be in the best interests of the woman. Conversely, if the midwife does not share of herself the woman may feel she does not 'know' the midwife. How much is 'right' is determined by the participants in the conversation. In offering her own story, Rose sought to support the woman who was experiencing breastfeeding difficulties. In doing so Rose set out to show the woman that she was not alone in facing her challenge. At the same time Rose made herself vulnerable by sharing her experience with the woman. When the midwife comes to know the woman over the course of several months, it may be that they share more with each other, if that is the nature of their relationship. Conversely, their relationship may be limited if the woman does not engage in the relationship or the midwife chooses not to share. Over the course of the relationship as they come to know each other, it is likely that boundaries flex to support care that meets the woman's needs.

From the woman's perspective

While the focus of the relationship is on the woman and her needs, this woman was curious about the midwife and her life.

> *It's nice to know a bit about their family, if they've got children, grandchildren, how long they've been a midwife sort of stuff. It's not natural to me to have someone come to my home and not get to know a little bit more about them on a personal level. I don't expect to know things that I don't feel comfortable hearing, so I think it's up to them what they feel comfortable sharing. I don't give away everything about myself when I first meet someone, it takes a while and the relationship builds over time. It's both getting to that point where you are happy to talk about things that are outside of pregnancy and birth and baby (Milly, woman).*

Milly wanted to know something about the midwife's world so she could understand more about the midwife as a person. She assumed that what the midwife was comfortable with sharing would also be what she would be comfortable hearing. What was appropriate would be determined by the midwife and the woman as the players within their conversation. It is suggested that "no one knows in advance what will 'come out' of a conversation" since "a conversation has a spirit of its own" (Gadamer, 2013, p. 401). In close relationships it may be easy for the midwife to forget her professional responsibility to the woman and 'overshare' from her personal life. In getting to know the midwife their relationship may be strengthened. Alternatively, the risk is that the midwife becomes less likeable if her personal attributes do not align with the woman's expectations. Strong self-awareness and interpersonal skills provide midwives with guidance in close relationships to enable them to consider what they share and how they manage their own emotions to keep themselves and the woman safe (Gardner & McCutcheon, 2015/2016).

Perhaps knowing the midwife was important because she was coming into this woman's home. Van Manen (1997, p. 102) describes home as the place "where we can *be* what *we are*". To be herself and feel truly comfortable with the midwife in her home, it may be that Milly needed to know the midwife was someone she could relate to, as a person. Someone who fitted into her home and family life. Perhaps Milly wanted to regard the midwife as a welcome guest in her home rather than a reserved health worker, someone who felt at home with her, so she in turn, could feel relaxed in her own home. Getting to know the midwife also influenced how much Milly shared of herself. When the midwife showed herself to be relational and trustworthy, Milly shared more of herself. It seems their conversations were far ranging, and this would have given her good insights to the character of the midwife. If they

found they had much in common it is likely that their conversation would flow back and forth with little effort, increasing their enjoyment and confidence in each other. In such relationships, they become authentic to each other. Yet even in their close relationship boundaries remained in the background, perhaps unnoticed unless they were breached.

Maintaining boundaries

Professional boundaries provide expectations and guidance for how the relationship can play out. They give an outline to work within. However, there are times when rigid boundaries may constrain the relationship and limit the development of trust (Smythe et al, 2017). On the other hand, if the midwife's boundaries are too open she may find herself compromised (Reamer, 2001). Midwifery care seeks to be responsive to the woman's situation and this may lead to boundaries flexing or perhaps boundary crossings. Such crossings may be justified so long as they occur in the best interests of the woman. Boundaries are described as a living thing that are "constantly being crossed or renegotiated by a variety of procedures, people and technologies" (Aylott, 2011, p. 810). However, boundary crossings may be a slippery slope to boundary violations and so require thoughtful consideration by the midwife. This section considers how midwives and sometimes women, maintain boundaries.

Reiterating boundaries

Boundaries require maintenance throughout the relationship.

> *What triggers me to reiterate it is probably a text that somebody has sent me in the middle of the night that they've had some bleeding and I wake up and see it. It angers me because I'm worried. How can you place that responsibility as a soon to be mother on me? That's not okay. It also makes me feel it mustn't be important because you haven't rung me. I do believe women will ring if it's important. But to text me for some bleeding. I don't think that's okay. I will ring that woman and say, I'm concerned about this text. At the end of the conversation if all is normal and well, remind them to ring me for that. It gave me a fright and it's not okay that you lie awake worrying and waiting for me to reply (Clare, midwife).*

The woman has not got it 'right'. The words 'some bleeding' conjure up all sorts of concerns for Clare. The woman knows what she has experienced but Clare can only read between the lines to imagine what is going on. The not knowing is frightening for both the midwife and the woman. While Clare trusted that the woman would ring if she was concerned, she wondered 'what if'. What if the woman and her baby were compromised? What if the woman had been awake all night worrying? What if her trust was misplaced? In the woman getting it wrong the

midwife was also vulnerable. What if the information she had given the woman had not been understood? The boundary Clare put in place to protect her own time, had the potential to instead become a barrier between her and the woman. Within the misunderstanding lies the risk for a loss of trust in each other. Trust is "built out of (and destroyed in) routine frustrations, promises and commitments" (Flores & Solomon, 1998, p. 223). While nothing untoward occurred, the 'what if' remained. Clare may wonder if she can trust the woman to contact her at the right time. The woman may wonder if Clare will keep her safe at the right time.

Following up on behaviour that falls outside of expectations is important to avoid the midwife or woman feeling taken advantage of. Boundaries that are crossed without any consequence soon lose their meaning and are likely to be subjected to further crossings. It takes courage to call out behaviour which is not in keeping with expectations, and it takes skill to do so kindly. The mobile phone is a tool that gives the midwife freedom to move about her daily life while remaining contactable. Yet the midwife never knows when it will call her. The call may be loud, demanding immediate attention as a ringing phone, or it may be a quieter ping announcing a text or email. Either way, the content may be cause for urgent action. It allows the woman to feel the midwife is 'near' when needed. Yet if the midwife resents the contact, or the woman hesitates, how near does it allow them to be? Nearness is not measured just by availability. It is about feeling a closeness, knowing the person on the other end of the phone, and feeling safe because of being known. What matters about the phone is whether it is a thing of reassurance which enables a feeling of closeness, even when apart. It may be that instead it heralds the demands on the midwife, or it may provide a barrier for the woman to contact the midwife.

Too many calls

Routine midwifery care is scheduled at a time that is mutually agreed. Between routine visits the midwife is on call for any urgent queries and for births. When the woman and the midwife have different understandings of what is urgent there is likely to be tension put on their relationship.

> *One woman would ring me every week. Then it became more often. She asked stupid questions like will my baby get a headache because he's upside down. I didn't have a lot of good humour at the end of that! I had to explain to her what was urgent and what wasn't, but it just did not sink in. In the end, I had to ignore her phone calls and just check the voice mails because it drove me insane. These constant interruptions with inane questions. It was almost like she just wanted to hear my*

voice. I don't mind if they ring me with a sensible question once in a while (Heather, midwife).

Within the relationship it is the woman who determines what is urgent, and to this woman it was everything. However, her repeated calls were not urgent by the midwife's understanding. Perhaps even absurd. Despite reminders from the midwife about what was urgent and what was not, the woman continued to call. By continuing to call she failed to recognise what was important to the midwife. Ignoring the woman was not really an option since the midwife had to check each communication from her, just in case there was something urgent. Yet each call that was not urgent represented a further boundary crossing and this began to erode the midwife's good will toward the woman. I wonder where the woman's family and friends were at this time. Was there no one else for her to talk to? It may be that each call was a test of the midwife. Could she be trusted to be 'there' when she was needed? It seems that despite the midwife sharing her knowledge, everything remained uncanny to this woman (Heidegger, 1962/2008). Yet in not understanding how the relationship worked this woman pushed the midwife further away, ironically the opposite of what she sought.

A woman who dominates the midwife's time, particularly over a prolonged period, can have a flow on effect to the midwife and perhaps the rest of her caseload. It can be hard for the midwife to remain compassionate and caring if she feels a woman is taking advantage of her. The on-call nature of caseloading practice often leaves the midwife sleep-deprived during daylight hours, making an unnecessary interruption even more frustrating. Within this relationship, the conversation was focused one way, to reassure the woman. With little or no reciprocity in the relationship it is likely the midwife felt she was giving, and the woman was doing all the taking. Despite sharing information this woman was not gaining confidence and seemed to take no responsibility for her actions. Her behaviour suggests a poor understanding of the midwifery service. Perhaps the midwife worried if she could trust the woman to keep herself and her as yet unborn baby safe. In knowing the woman and being on call for her, it seems this midwife became the only point of contact for the woman. Such relationships can feel like hard work, especially when the midwife has no one else to help her with such demands that feel increasingly unreasonable.

Inappropriate timing of texts

The advancement of telecommunications, the internet and social media are a double-edged sword for the caseloading midwife. While they give her freedom to move about, they also

create the expectation that she is immediately contactable, anywhere, and at any time. It can be appealing for the woman to consider that a trusted health professional who ‘knows me’ is available 24/7 to respond to her concerns.

> *I tell women I won’t hear a text at night so if it’s urgent you have to call me. This week I had a text at 3 o’clock in the morning. I woke up at 7o’clock to find it, asking if she can take Gaviscon for heart burn. I was so irritated as to why anybody would text me at 3 o’clock in the morning. Then I thought, don’t be silly she probably woke up with heartburn at 3 o’clock in the morning. She never thought that I’d be sleeping at 3 o’clock, let me just wake her up. I’m thinking that’s unthoughtful. I felt guilty for being angry at her for texting at 3 o’clock in the morning even though I didn’t get the text until 7 (Carol, midwife).*

Sometimes it is the little things that annoy the midwife. Texts out of office hours, or phone calls for non-urgent matters. This midwife was annoyed that the woman had tried to contact her while she slept, and then annoyed with herself for not being more tolerant of the woman’s concern. If the midwife experiences constant interruptions to her ‘down time’, she can start to resent the woman that she set out to help in the first place. Carol’s irritation may be a sign of a loss of joy in her role which in turn may be a sign of pending burnout (Young, 2011). Being on call 24/7 is a huge expectation of a midwife. At any time, a woman may contact her for something that is routine or perhaps urgent. The midwife is waiting to be called, but perhaps hoping she will not be called. Does she carry on with her life, or put things on hold? It may be that interruptions are better received if the midwife enjoys being with the woman. Or perhaps the woman who is enjoyable is the one who calls less.

Living a life on call requires the midwife to make herself constantly available. She lives with the constant uncertainty of ‘what if’. Each out of hours call or text carries the possibility of being an emergency that the midwife must respond to with consequences if she gets it ‘wrong’. Perhaps this midwife had a physical reaction to the text. Perhaps she worried ‘what if’ she had slept through an emergency call. ‘What if’ the woman or her baby were now in harm’s way because she had not heard the text. Her relief at the routine nature of the enquiry was evident. This midwife was able to empathise with the woman as someone who was known to her and who perhaps she felt was worthy of her support and care. While being on call is likely challenging, it seems the relationship is protective of the midwife. I wonder how long periods of time on call, living with uncertainty and wondering with each text or call, ‘what if’, impacts the midwife’s relational capacity?

The midwife sets boundaries

Within the midwifery relationship the woman brings her knowing and understanding. There may be times when this does not align with the midwife's knowledge and ways of working. At such times, the midwife must draw on her professional responsibilities to support the woman. This may not be straightforward.

> *I cared for a woman who wanted a stretch and sweep at 37 weeks. We talked about why I wouldn't do that. She said her previous midwife did them every week and she cried. I told her that she was asking me to do something that I could not back. We talked about the things that could go wrong and I told her that her best chance of having a successful VBAC was to leave things alone and let her body sort its own timing. She was still not sure, but she left it. She had the most fantastic birth at 41 weeks. Afterwards she sent me a letter saying, 'thank you for doing your job and not being tied into my emotions, and for giving me the birth that I always wanted'. And all I did was nothing. It was a good lesson because when I refused it was like oh what am I doing? They may hate you for a minute but ultimately they will know you did the right thing (Deb, midwife).*

Standing up to this woman was not easy. Her request made no sense according to all that this midwife knew. The woman wanted a normal birth and saw the care that her previous midwife had provided as a pathway to achieving it. Yet this went against all that Deb knew. This conversation had the potential to go badly wrong. This woman trusted the care her previous midwife had provided yet here was another midwife saying it was not correct. Through conversation they reached an understanding of sorts, enough to move them forward. It is likely the woman took a leap of faith that the midwife was right. Having to wait and do nothing may have felt wrong to her. Yet waiting and watching is key to midwifery care. We can only speculate what might have happened had the midwife acceded to her request. But in doing nothing, it worked out well. I wonder though, how might the relationship have fared if the birth did not go as she hoped. Would she have blamed the midwife for not following through on the care that she thought was important? In taking a stand this midwife took a risk that paid off.

The woman sets boundaries

The focus of midwifery care is on meeting the needs of the woman. This means that there are times when midwives may offer to cross boundaries in response to a specific situation.

> *In the early days after the move my old midwife was in constant contact to make sure that the new midwife had all the information she needed and that we were being supported the way that we needed to. It's probably considered unprofessional, but she even said that if we really needed it and we felt really scared that she would come and be a birth support person. She doesn't have time to be driving all the way*

to another area and trying to help us. I'm very much like we'll be okay! I definitely didn't want to put that on her. Had there been further complications we may well have asked her to have come and visit but she's got her own caseload to deal with. I have enough insight into midwives' caseloads that I would never want to interfere with that because that would be interfering with other mothers and their experiences as well (Jo, woman).

Jo's midwife provided a thorough handover to the new midwife. However, it seems she remained anxious whether the new midwife would look after this woman 'properly'. When the midwife offered to attend as a birth support person, Jo declined her offer. Perhaps it was reassuring for Jo to know that someone she knew and trusted could be with her if she needed her. While she appreciated the offer, it did not feel right to her for the midwife to travel so far and she worried about the effect on the other women in the midwife's care. Perhaps the midwife was overextending with her offer and missing the cues that Jo had moved on. While they had enjoyed a close relationship, perhaps Jo looked forward to the new relationships which would support her going forward. One wonders if it was possibly the midwife who was reluctant to 'let go' of this relationship, with an unspoken yearning to see her care through the birthing. Perhaps she sought to be helpful. Relationships by their very nature have a two way 'tug'. This story shows how the midwife can get it wrong, as well as the woman.

When boundaries are tested

The midwife-woman relationship is described as a partnership based on the concept of "shared responsibility" (Guilliland & Pairman, 2010a, p. 41). However, not all women will accept this responsibility.

I was covering a colleague and I got this text message, 'I'm bleeding everywhere, I'm dying'. I was really distressed because she didn't answer her phone and I didn't have any information about her. I knew where she lived but had no other alternative phone numbers. I thought what do I do now? I got in my car and I went to the house and they were having a party. She said, 'oh we were joking'. That really tested my boundaries, so I said to the whole group of midwives I worked with that I was no longer accepting text messages. It was the biggest learning curve I ever had about the dangers of text messaging. It's never happened again but we've got to put boundaries in place to keep ourselves and the woman safe. After that I give every woman and everyone I covered for, a piece of paper saying that the woman has to ring, and I will not accept text messages. I tell women to keep $5 baby credit on their phone because that's the baby's safety credit. Most women are pretty good, and they will phone (Annie, midwife).

Communication via text is fast and efficient. However, while communication via text is suitable for simple messages it was not suitable for this situation. Annie needed to talk with

the woman and soon. The woman was not known to her and she had to trust that the call for help was authentic. The text described an emergency that was frightening, and one that Annie needed to respond to. However, the woman's behaviour abused the trust between her and the midwife. Trust that is damaged may take time to re-establish, but the memory of the abuse will remain (Flores & Solomon, 1998). As a consequence, this midwife was determined to never feel so vulnerable again. Her reaction was to set up a system to ensure that women could not abuse the relationship by text again. As a midwife in the community working alone, Annie was vulnerable when she responded to an emergency call from an unknown woman. Such an event was a one off by a silly girl at a party. I can only imagine the discussions that her midwife had with her. Perhaps she was apologetic. Or perhaps she had little insight into how much she had frightened this midwife. This midwife's reaction suggests the fear that comes with practising in the community with limited back up and support. Her response of tightening her boundaries suggests a need to feel in control of something that was beyond her control. It seems that this midwife's ongoing trust was marred by the memory of the abuse of her trust.

Flexing boundaries

There are times when midwives respond to a need that presents and in doing so cross a boundary they have set. An example of this may be transporting the woman to hospital in the midwife's car.

> *Once in a blue moon you'll find yourself in a situation where you're with a woman who needs to go to hospital and there's nobody with her and actually the quickest and easiest thing to do is pop her in your car and take her. I've done that probably three or four times. I don't think that I should be a taxi driver but in those instances I'm not going to sit there waiting for the partner who doesn't come home or leave a woman who might be in danger (Rose midwife).*

Transporting the woman to hospital was not Rose's usual practice. But occasionally the situation arose where it seemed the most practical thing to do. She weighed up the risks of leaving her at home until her transport was available against taking her in her own car. But I wonder if the woman was aware that giving the woman a ride in her car was not this midwife's usual practice. The risk lies with the woman sharing with her friends who then come with an expectation that the midwife will do the same for them. If she does not, perhaps she risks that relationship. As well, it may be difficult for the midwife to sustain such ways of working if her caseload increases. Boundary crossings may be done with good intent but can have unforeseen consequences.

When a midwife's boundaries are too open

Boundaries set out to protect the woman when she is vulnerable.

> *I think being pregnant is one of the most vulnerable times of your life. I'd had a miscarriage earlier, so I was quite anxious at the beginning of my pregnancy that things were going to go wrong. I looked to her for a lot of support and maybe she should have directed me to some form of counselling. I put a lot into our relationship and my opinion would be that as the professional, she could have created a better boundary for our relationship and provided more of a referral system. I think it was natural to let your guard down, as I was sharing really personal information with her. With your boundaries going down you're putting a lot of trust in them. I spent a lot of time confiding in her and about my fears, when maybe it would have been more appropriate to get someone else to talk to me. I thought she could have been more professional. But then I didn't think about any of this until afterwards. A certain level of professionalism is important in terms of creating boundaries, especially for first time mums knowing that they don't really know what's going on half the time (Kiera, woman).*

At the start of their relationship Kiera trusted the midwife. In trusting this midwife she let her guard down and shared information that felt very sensitive. Perhaps thoughts and feelings she had not shared before or maybe even realised before. But somewhere along the way she came to regret sharing so much. Perhaps in trusting too soon she felt foolish. It seems the confidence she had in the midwife was gone. Maybe the midwife did not offer the support she sought or perhaps the relationship did not develop in the way that Kiera had expected it to. I wonder what professionalism this midwife brought to this disclosure. Did she reassure her the conversation was confidential, or that it would not be documented without her consent? This might have saved the relationship by giving her a sense of control over the information she had shared. It seems it is the midwife who has to create the balance in the relationship between being supportive while remaining professional, even if the woman takes it to a more personal level.

The consequences of no boundaries to protect personal life

While the focus of midwifery care is the woman, the midwife who neglects her own wellbeing may find it difficult to care.

> *I never had a problem with a woman ringing me in labour or for a fetal movements or whatever. But it got to the point where I stopped organising things for myself. I stopped saying to friends I'd love to go out for dinner because I was always on call. The number of times I was disappointed, and I had to disappoint my friends. I just steadily stopped having a life. I think that was the big thing. I was so tired I didn't want to plan anything for my weekend off. I thought this is not a life. All I do is work.*

> *It's hugely fulfilling. But I want to talk to people about something other than pregnancy and babies (Heather, midwife).*

Being on call can be all consuming to the midwife. Heather sought to provide care that prioritised the needs of the woman, but over time she realised that this was at a cost to herself. Slowly she stopped doing the things that she enjoyed. She neglected her relationships with family and friends. Heather trusted the women she cared for to respect her boundaries. When they did not, she felt abused by their closeness. In time she started to feel she was being taken advantage of and came to resent the very women she wanted to care for. Being on call means a life of waiting, not knowing when the next woman will go into labour. It is the call that keeps the midwife out of bed for 24 hours or longer that takes its toll. Scheduled time off call is important to sustain midwives (Crowther et al, 2016). Assessing women's expectations and setting clear boundaries are factors which protect midwives from burnout (Young, 2011). In giving so much Heather left nothing for herself. For midwifery to be sustainable, the relationship needs to sustain both the midwife and the woman.

When 'knowing' blurs the boundaries

The midwife-woman relationship has "the potential to be mutually rewarding and enriching" (Deery & Hunter, 2010, p. 38). However, within close relationships it remains important for the midwife to maintain her professional responsibilities. The term 'professional friend' has been used to explain the professional relationship between the woman and the midwife (Pairman, 2006). The notion of being a friend may reduce the understanding of professional responsibility that midwives have. This section considers stories where boundaries have become blurred.

Midwives come to know a lot about each woman and her family

The midwife-woman relationship has been described as a "personal relationship, akin but not identical to friendship" (Wilkins, 2010, p. 74). The relationship develops during a period in her life that includes significant changes for the woman and her family. Through conversation the woman and midwife can come to a deep understanding.

> *We almost are a professional friend because we know so much about the woman, it's not just about a pregnant uterus is it? It's about the whole person. We know about their families and we know about things that are happening in their lives that they may be worried about or exciting things. If a woman asks about my week I'd just say oh great, beautiful weather or something like that, rather than tell them all about what I've been up to. As a midwife I've got my professional clothes and it comes with that*

> *professional persona and I'm thinking about what I say, and what I share (Heather, midwife).*

In coming to know so much about the woman, this midwife felt a closeness in their relationship. Despite this she was careful about what she shared about herself. Women only knew information that she was happy to share. Gadamer (2013) describes the experience of the Thou where there is mutual respect for each other's autonomy. Yet there is another side to such closeness. Gadamer suggests that the experience of Thou seeks to predict the behaviour of the other more so than seeking understanding, because this makes it easier for ourselves. He also suggests that viewing the other as Thou can suggest that we "understand them better than they understand themselves" (Warnke, 2002, p. 92). He suggests that if we are to truly experience Thou we need to be open to the other and recognise their autonomy. Perhaps the successful relationship is about the woman feeling listened to and understood. May be it is to have someone focused on 'me', listening to 'my' concerns and sharing in 'my' excitement.

Woman needs to respect the midwife

Jane had a clear understanding of the midwife's responsibilities within their relationship.

> *It is like a form of friendship but it's a professional friendship. It's almost like they're the boss and employee. You can be friends, but you still have to have that little bit of professionalism so that they can have that respect and stuff with you (Jane, woman).*

Jane enjoyed the warmth and closeness of the relationship. However, she expected the midwife to meet her professional responsibilities as this would contribute to her feeling safe. Jane wanted to respect the midwife as someone who was professional. Being professional entails having knowledge and skills, self-awareness, and providing care that is in the best interests of the woman (Guilliland & Pairman, 2010a). But for Jane professional also included a relationship that was authentic and warm from a midwife who knew her. It is a balancing act for the midwife to understand each woman's needs and to respond to her accordingly with warmth and friendliness while also maintaining the professional gaze. Unsurprisingly, there are times when the woman or midwife misunderstand the cues within the relationship.

Being asked to be 'godmother'

Feeling close may lead to one or the other misinterpreting the relationship.

> *Going to people's homes changes the dynamics. You chat about other things and there is a realisation of similar interests. I was asked by a woman if I would be the*

godmother. That was really difficult. I was really shocked when she asked me, and I thought wow, what do I say here without offending her. I had to say to her I'm sorry this is an honour that you ask me, but I can't because it wouldn't be acceptable within my profession. Here's a woman who's interested in me and blurred that line. That was in the first couple of years. I kind of stepped back a little bit more (Heather, midwife).

Understanding relationships can be tricky. This woman and midwife had enjoyed their time together and this led the woman to assume that the relationship would continue. Her request was a surprise for Heather for while she had enjoyed caring for the woman she did not see the relationship continuing. This led her to review how she communicated her professional role. Managing boundaries in close relationships is something that midwives learn on the job. It draws on their understandings of what is 'right' at that moment. The midwife-woman relationship is intense over a specified period of time with the focus on the pregnancy journey and meeting the needs of the woman. This includes particular tasks and experiences that the woman and the midwife work through together. While they may feel close and enjoy each other's company, it is in the context of that journey that the relationship is understood. To move outside of that context requires the relationship to be revisited to ensure a shared understanding of any ongoing relationship. To manage blurred boundaries Heather drew back from sharing as much of herself. Yet it is evident from stories such as Milly's, that women seek to know something about the midwife. Managing close relationships can be tricky.

Providing care to friends

Providing midwifery care entails professional responsibilities and accountability to the woman. When the midwife chooses to provide care to a woman who she has a close pre-existing relationship with she is urged to consider the "potential to lose objectivity in decision making" (Midwifery Council, 2010, p. 3). Such relationships may challenge the midwife to meet her professional responsibilities.

When I was first qualified I wouldn't deliver my sister, I didn't deliver my best friend, I just couldn't do it. But recently one woman and her family have become really good family friends. I wouldn't have picked it when I was looking after her. They were just people that I got on with like any other client. Then at five months she had a breakdown and he rang me in the middle of the night. They never rang me out of hours during the whole pregnancy, so I knew it was serious. I calmed him down and said bring her and meet me tomorrow for coffee and we'll chat through some things and I can point you in the right direction. I talked to them about sleep solutions, she was just really sleep deprived and we went through things like that. A couple of months later I rang. Things were much better, and she was seeing a counsellor for her anxiety. Then my mum died, and she found out and turned up with food. They

> *come from the same part of the world as us and our husbands got on really well. We've become really good friends. We are like substitute grandparents to those kids. With her next pregnancy all her antenatal checks were done at our house but when the baby stopped growing toward the end we met at the clinic. I said there are times when I'm your friend and times when I'm your midwife and we have to differentiate those conversations (Deb midwife).*

Something happened that changed this relationship. Deb had completed her care for this family, but they reached out to her when something was not right. Her response was as a caring person who could help them navigate the health system to access the support they needed. I wonder why they turned to the midwife rather than the GP or well child nurse who would have been part of their ongoing care? Could it be that their relationship was sustained even while they were apart? It seems they appreciated the midwife's generosity as in return, they responded as people in her community who cared when they heard about the loss of this midwife's mother. Maybe it was when the husbands met that the relationship changed. As a midwife with many years' experience Deb felt more prepared to manage overlapping relationships. It seems that Deb wore different hats for the two roles she played in this woman's life. One as the friend and substitute grandparent, and the other as the midwife. It seems that generosity opened the way to an ongoing relationship that worked well for this midwife. However, it is suggested that close relationships that form during the pregnancy may also cloud the midwife's decision making. Thus, midwives are encouraged to discuss their care with colleagues and the woman (Midwifery Council, 2010). Such relationships call on the midwife to be attuned with the woman to protect the trust that is present.

Deciding not to provide care to friends

Not all midwives feel comfortable caring for friends. The potential risk that lay within that care relationship meant that Annie chose not to do so.

> *I'm quite black and white about a few things. I'll facilitate things, but I don't care for friends at all. Very early in my midwifery practice I cared for a friend who had a difficult birth. Thank goodness I had a good backup midwife with me, and everything was fine. It was a very big learning curve. I thought I don't ever want to put myself in that position with someone who is a friend. I felt if things had gone pear shaped, it would be messier than someone who wasn't a friend. I've recognised early on in my midwifery career that midwifery has this immense responsibility to it and blurring boundaries was going to cause more anxiety for myself (Annie, midwife).*

As the midwife Annie was accountable to the woman for the care she received. Her near miss experience showed her the far-reaching effects an adverse outcome may have on not only her practice but also on her friendships. This led Annie to consider ways that would keep her safe and that included the decision to not care for friends. In leaping ahead, Annie

sought to keep herself, and potentially the woman, safe. When boundaries are blurred any breach of trust or breakdown in the relationship has a wider impact on the woman and the midwife as they look to family and friends for support. When the midwife sits amidst that group, loyalties may be divided. The ripple effects of the relationship breakdown may challenge confidentiality as others seek to interpret events.

Conclusion

The midwife-woman relationship is guided by professional frameworks and bounded by contractual responsibilities. While these are explicit, how they are communicated and lived out is not always so clear. The midwives described how they set boundaries in order to protect themselves and how they communicated these to women. However, women struggled to understand how these boundaries worked in real time. When they got it 'wrong' the midwives would remind them of their expectations. If mutual trust was present boundaries could be relaxed in a way that both implicitly agreed, maybe because they valued the relationship. Boundaries set out to protect the woman and the midwife. However, boundary crossings could contribute to strengthening the relationship by showing the woman she was trusted, or in situations when the midwife provided additional care in response to a specific situation. Both midwives and women in this study expected the woman would remain the focus of the midwife's care, although this could include the woman knowing a little about the midwife as a person. Perhaps enough to know that she was authentic.

Close professional relationships have the potential to blur boundaries. Occasionally they may move to a friendship, however, midwives in this study sought to keep a distance between themselves and the women for whom they cared. Boundaries that are blurred can result in confusion for the woman, and also sometimes for the midwife. As a consequence, there may be discordant expectations regarding ways of working together. If any challenges arose within the relationship, the women expected the midwife to manage these due to her professional role. However, setting and maintaining boundaries was not always straightforward. The next chapter will explore experiences when there are tensions in the relationship.

Chapter 7: When tension arises

Introduction

How we engage in relationships is influenced by our previous experiences. Perhaps we have experienced trusting and cooperative relationships, and/or maybe relationships that are controlling or frightening. All relationships require work to be successful, although some can be more challenging than others. Some challenges may be resolved by a commitment from both parties to engage in conversation towards gaining a shared understanding. This assumes that both wish to engage in or value the relationship. However, some challenges may feel insurmountable. Working with challenges can create tension and may even lead to a breakdown of the relationship. While the woman's childbearing journey has the potential to build self confidence and trust in others, it may also lead to a sense of failure and mistrust (Lundgren, 2018). This chapter explores the experience of when the relationship feels 'wrong'. It considers relationships where each have different expectations and relationships where boundaries are crossed. Finally, it considers stories where the midwife and/or woman has worked through the tensions that arose in the relationship.

Different expectations

Both the woman and midwife come to the relationship with an understanding of what the childbearing journey may involve. It is likely this includes expectations about how their relationship may play out, and perhaps how the birthing journey may unfold. Such understandings may be revealed through conversation, although this is dependent on how the conversation plays out. Whether it is open, or not. If each have diverse understandings this may create tensions within the relationship as they struggle to understand each other's position. Working through such tensions requires a commitment from both to engage with the other and to be open to 'other' ways of thinking. If a shared understanding is not reached, trust between both is likely to be eroded. This section explores stories of when different expectations create tension in the relationship.

The midwife didn't know what the woman needed

The relationship can be difficult when the woman and the midwife have different expectations of what care involves. This may impact on their confidence in each other and in turn affect the relationship.

> *A woman I am caring for rings me a lot. I think she sees me as an information provider and she obviously feels she can call me. I think she trusts my judgement*

because I'm the professional, but I don't feel she has respect for me. I allow extra time for her appointment because there are so many questions. I'm not looking forward to her labour and that's not me. I decided I was going to ask her if the relationship was working for her and maybe she should find someone else. Then her husband came with her for the next couple of visits. They come from a medicalised country and I had to consider that perspective as well. The relationship doesn't feel as if it is two way. I feel like I'm not what she wants me to be. I feel like I'm constantly saying this is normal, and I don't know if that's what she needs (Judy, midwife).

The relationship did not feel 'right' to Judy. The woman kept asking questions and it seemed that despite all the information she had shared, this woman was still not reassured by her responses. The repeated questions led to her feeling the woman did not respect her advice. As well, Judy wondered if the woman felt safe with her and whether she was the 'right' midwife for her. In looking ahead, Judy worried how the birth may play out if this woman did not trust her to do what she needed to do. Flores and Solomon (1998) suggest that "distrust can be seen as a kind of pessimism" (p. 214). It seems neither quite trusted the other and this left the midwife feeling vulnerable, and perhaps the woman as well. I wonder what this woman was thinking as she moved toward the birth with care that was so different from her home country. Perhaps she wanted to trust this midwife and the different approach but wondered if she was safe. But what if the woman was not challenging the midwife's knowledge but instead sought reassurance that her new understanding was robust? Perhaps for this woman it was difficult to trust the midwife who worked in a way that was so different to that which she was familiar.

The arrival of the woman's husband changed the dynamics of the relationship. It seems his presence reassured the woman that all could be well, and that she should trust this midwife. It appears the midwife was also reassured that this relationship may work after all. Maybe once the husband was reassured by the midwife's advice his wife was able to share in his confidence. Maybe it was their commitment to making the relationship work that made the difference. However, Judy was aware that the forthcoming birth would test their new understanding and she continued to worry about how this may play out. It is clear that they shared conversations, but perhaps this was an exchange of words rather than the creation of a mood that could reassure both (Heidegger, 1962/2008). Maybe their conversation lacked the back and forth of conversation, and instead was focused on the things that concerned the woman. Maybe she knew she needed to give an update to her husband when she went home so had to get her answers clear in her mind. Such relationships can feel like hard work as the midwife seeks to understand what is important for the woman. While her relationship remained with the woman, approval from the husband contributed to a relationship that felt

like it had more potential. It was the potential for a positive relationship that contributed to this midwife's tentative confidence that she could provide care that mattered.

She didn't know

Not all midwives get it 'right'. Sometimes the midwife does not recognise the woman's vulnerability.

> *The doctor came in and went over the birth. She apologised for the way it went and she explained everything that happened, which was good. I think my midwife visited me, but she was just another person. I didn't feel like we had anyone that was right there telling us what to do. I think my baby and I came very close to dying. They said it was touch and go. I don't really think my midwife knows quite what I've been through. Afterwards I got bad haemorrhoids and I felt like everything was going to fall out any time I stood up. My midwife kept saying, I'm sorry that happened to you and it was unfortunate, but things will heal, and you'll be fine. She was nice, but I didn't feel like it was fine (Amy, woman).*

Amy's birth had not gone as she had expected. While the midwife was sympathetic, she did not seem to understand how overwhelmed, and at times abandoned Amy had felt. It seems the midwife was physically present but her way of working with complexity was to hand over to the hospital midwives. It seems Amy did not expect this and had no framework to understand why her midwife receded into the background at a time when she needed someone to guide her. It is likely that the midwife was not aware of the depth of Amy's concerns and instead believed that her reassurances were enough. It may be that Amy's perceived brush with death changed how she viewed her world. Perhaps the life that she had taken for granted, now seemed more fragile and less certain. The body that she had known and trusted no longer felt familiar. Now instead, it threatened to 'fall out' whenever she stood up. To the midwife, the birth was 'unfortunate' but something that this woman would heal from and get over. Although this was part of the midwife's knowing, Amy had no experience to draw on to reassure herself that this feeling would pass. Instead, there was an unfamiliarity about herself that the midwife did not appreciate and so could not remedy (Svenaeus, 2011). It may be that the doctor's debrief only served to increase this woman's anxiety about her birth. I wonder if the midwife was aware of what the doctor had said.

Perhaps Amy could not articulate why she felt so uncanny (Heidegger, 1962/2008) and unlike her usual self. Van Manen (1997, p. xiii) states that "language is inadequate in describing our experience … because language is essentially social". How does one describe how one feels when such feelings are perhaps raw and painful? It may be she

worried that in grappling to find words to explain her experience she might inadvertently offend the midwife. Or that her concerns may be viewed as a criticism of the midwife. It seems that even in her distress she did not want to offend the midwife. Was that because she valued the relationship, or was she worried about her ongoing care? It may be that she did not want to be a 'nuisance' and so pretended that all was well. This mean that both continued in the relationship, the midwife likely feeling confident she had reassured the woman, while the woman felt concerned and misunderstood. It takes time to open the conversation and courage to address the lack of attunement. What may arise through the conversation is unknown and this may be reassuring, or frightening. In a mood of angst it may have been difficult for this woman to find anything that felt familiar and homelike. I do not know if the midwife made time to talk through the birth. Maybe this woman needed multiple opportunities to try and find the words to tell her story. A recent study suggested that women and midwives waited for the 'right' time to talk (Waller, 2018). What if the 'right' time never arose?. It may be that the busy midwife has other things on her mind – the other women she was caring for, or perhaps her need for catch-up on sleep.

Distance in relationship

Not all women seek a close relationship. This may leave the midwife struggling to understand what is important to the woman and in turn, uncertain how to provide care that matters.

> *I struggle with women who don't seem engaged. This woman didn't have transport, so I agreed I would home visit. She said, "do you have to come so often? I never saw my midwife in Australia this often". She would question everything, like what do I need another scan for. She was obese, and I wasn't 100% sure her baby was growing well but she wouldn't have one. Then postnatally she's like, "he's gaining weight, and can't you leave it for a few weeks?" I told her that I need to visit you this number of times. Then when I knocked on the door she told me "you can't come in right now as it doesn't suit me". I find that frustrating and concerning for the woman and the baby. I'm not there to be annoying. I'm there to provide care but she didn't want the care as she felt it wasn't needed but there was no rationale or discussion (Judy, midwife).*

It is clear that this woman and midwife had different expectations of how care would be, and this was affecting their relationship. Perhaps the woman was confident all was well while the midwife was not so sure. Maybe the woman just wanted to get on with her own life and thought the midwife was overly anxious. When the woman limited her access, the midwife worried. Judy could see potential for things to go wrong and wanted to be reassured. In the absence of a shared understanding of what was important Judy worried whether she could

trust this woman to know if something was wrong, or to call her. What if there was an issue that went undetected? Would a misunderstanding lead to an unjustified complaint? The woman's responses served to further undermine Judy's trust of her. Trust is described as "bidirectional… that is, the person trusted typically trusts the trustor in certain ways as well" (Flores & Solomon, 1998, p. 210). It may be that in this relationship, neither trusted the other to do what was 'right'.

Judy had agreed to travel to the woman's house for their appointments, yet the woman did not seem to appreciate her efforts. Perhaps the relationship worked for this woman, but it felt different to those the midwife usually experienced and enjoyed. A relationship where the woman does not heed the midwife's advice and the midwife is feeling anxious, does not feel like a partnership to me. Where was the negotiation or shared responsibility? Rather the lack of conversation and shared understanding made this relationship more like a transaction of midwifery care. In response, it seems that this midwife adjusted her expectations of the relationship and instead focused on providing care that met her contractual obligations. Such ways of caring would get them through this birth and thus this episode of care. Perhaps the changes in the relationship met the woman's needs and in turn, she grew to trust this midwife. Assuming nothing untoward occurred, perhaps Judy grew to trust the woman's judgement that all was well. It may be that it is only in hindsight that some relationships can be understood.

She didn't care

On the other hand, it may be the woman who seeks a close relationship and the midwife who does not. In this story the midwife was part of a caseloading team employed by the hospital.

> *I didn't feel the midwife was very caring. She was a bit rough and it looked like she only needed the information to put into the system. She didn't come to see me at home. I wasn't told if the blood tests were good, or if there's an infection in my urine or things like that. They were telling me that we're here to care for you, so I assumed she read my file. The way she spoke to me was very disrespectful. She treated me like I knew nothing, and she knew everything. There was no compassion in her voice. The most annoying thing was when she would make promises that she didn't keep. Sometimes she would ring me up and say I'll see you on your clinic day. But every time I'd go into my clinic day she wasn't there. The receptionist told me she was away on leave. Sometimes she arranged for someone else to see me, but that person never came. There was no one to sit down and say look you've been gaining a bit of weight and we're worried, there was no talk like that. I should have*

> *questioned her. She rang after the birth and didn't even know that my baby had died (Serena, woman).*

Serena expected certain things to be part of her midwifery care. Things like seeing her at home, knowing the results of her tests, being treated with respect, and having her contribution valued. Instead it seemed this midwife was focused on meeting her own requirements, such as gathering information and organising tests, with little time given to what was important for Serena. There appeared to be no time for the 'niceties' of the relationship, like any conversation beyond what was required. Perhaps in the busyness of everyday work, it was difficult for this midwife to find time for anything beyond completing the tasks of midwifery care. But such behaviour suggests she was overwhelmed by her commitments. The absence of time to talk and to get to know each other undermined Serena's confidence in this midwife. While the play of conversation contributes to the development of a shared understanding, what is said is less important than the mood that the conversation creates. Serena began to wonder if she could not rely on the midwife to be 'there' for her now, then maybe she would not be 'there' in the future either. In the absence of anything to reassure her that this midwife was 'right' for her, Serena lost confidence in the midwife.

Trust is important within the relationship. Serena was already concerned about whether she should trust this midwife. When the midwife made promises that she did not keep, Serena's concerns seemed vindicated. It may be that the midwife's colleagues did not keep the appointment, but to this woman the responsibility remained with the midwife who had agreed to care for her (and rightly so). Despite her growing concerns, Serena felt unable to question the midwife or look for someone different, and so she remained in the relationship. The death of her baby was the ultimate betrayal of trust that this midwife would keep her safe. Such a relationship does not sound like partnership to me. Where was this woman's empowerment? What happened to informed choice and consent? Perhaps this midwife was away, but it seems that her colleagues did not communicate well. We do not know if the midwife was aware of this woman's concerns. Nor if the midwife made any attempts to bridge the gap in their understanding. It may be that the midwife was grateful that this woman accepted the relationship as it was, as she contended with the competing demands of her busy workload. But I wonder, what did it feel like to be 'cared' for by someone who did not seem to care? Did her presence become unwanted? Perhaps her touch unwelcome?

Women come with expectations based on their previous midwife

One situation in which tension may arise is when a woman seeks care from another midwife. She now needs to build a relationship with the new midwife. However, she may find it hard to let go of her expectations built within a previous relationship. Midwives can sense such tension:

> *I find it hard when you take someone who has been looked after by a different midwife previously. I don't tend to have any issues with anyone when I'm the only one that's ever cared for them. When it's the first time they've done it, they know no different, so it's fine. They've chosen you and you've both worked through it together. When they've had a fabulous relationship with another midwife who has either retired or they're in a different area, you're constantly having to fill somebody's shoes. The relationship is still with the other midwife and they've got to start again with you (Deb, midwife).*

While the midwife has experienced many relationships relating to the childbearing journey, the woman may only have her own experiences to draw on. This means the woman may come to the relationship with an understanding about the type of care the midwife 'should' provide. Deb knew from previous experiences that the woman's assumptions could make this new relationship tricky. With her previous midwife the woman had felt understood and safe. It is likely the previous midwife came to know her so well that she could anticipate what was important to her. In turn this woman accepted that the care that midwife gave was 'how it should be'. It is inevitable that the new midwife will have differences in how she practices and engages with women. Yet for this woman each difference may have heightened her sense of loss of someone who was familiar and trusted. Or perhaps created an unease regarding which approach was best. Additionally, while each pregnancy and birth are unique, subsequent births are usually easier than first births. This means that previous care may be reviewed with a different understanding.

It takes time for the midwife to come to know the woman and to anticipate what is important to her. To do so also required the woman to be open to this relationship. In looking ahead, Deb was aware that she needed to work on gaining the woman's confidence that this relationship could work. It is through the relational skills of the midwife that the woman comes to feel she is understood. In turn this contributes to her feeling safe. And it is through feeling safe that the woman can get on with the business of birthing. Creating such a mood takes time and skill to uncover what matters to the woman and to gain her confidence and trust. This may be easier in some relationships than others but is part of providing midwifery care that feels safe to both. Such relationships take time.

Too familiar

There is a risk that the closeness that may develop within the professional relationship may result in assumptions by either the midwife or the woman. This may lead to times when their expectations do not align, leading to tension in the relationship. Failure to address these tensions may interrupt trust within the relationship. Trust once lost may be hard to regain.

> *My first midwife was the only one available who lived locally. I spent a lot of time confiding in her about my fears and sharing personal information with her. It started really well but didn't end well sadly. My birth went haywire and my partner and I weren't happy with some of the decisions she made. I had high blood pressure and my midwife was adamant that I go on pills. When my GP checked with the obstetric team they said no, it's not high enough. My midwife was upset with me and asked if I trusted her knowledge. I felt too scared to say anything about what I wanted, and I didn't want to rock the boat. I think laying it out on the table a bit earlier might have been healthier. She might not have ended up my midwife, but we might have felt kind of okay. Now if I bumped into her on the street I would be horribly embarrassed, and I would struggle to have a normal conversation with her. Which is stink, because she was part of this massive part of my life, but it didn't end well and that's something to regret (Kiera, woman).*

Kiera's relationship with her midwife started out feeling close. However, her confidence in the midwife was challenged when the midwife's concern about her high blood pressure was not shared by the obstetric team or her GP. The difference of opinion put her in a difficult position. Who should she trust? Flores and Solomon (1998, p. 207) suggest that if one trusts then "nothing need be said". However, to ask about whether one is trusted is to already indicate the possibility of distrust. By raising the topic, it seems the midwife sought to open the conversation by making her concerns explicit. However, Kiera did not feel able to respond honestly and so the conversation did not progress. It may be that both hesitated to raise their ongoing concerns out of fear of upsetting the other. The failure to address the tension developing between them meant that it continued to grow. We do not know what challenges the midwife faced in her own life. Perhaps she struggled to know how to manage the relationship that had started so well and then went so wrong. Regaining trust is not straightforward.

A birth going haywire suggests that labour and birth were not what this woman expected. Something changed. I wonder whether things needed to change to keep the woman and her baby safe. If this was the case, it seems the changes were not worked through in partnership. There is a sense the woman felt 'let down'. This story reveals how vulnerable trust is within a relationship. Despite spending time together and sharing an important event

in Kiera's life, the midwife's presence ended up feeling unwelcome. When this woman initially shared her very personal experiences with the midwife it seems she instinctively trusted her enough to do this, yet somewhere along that way that trust dissipated. How? Why? Was there a particular situation or more a growing mood? When the issues she described came along, had she already begun to lose her trust? Did one moment of not feeling her midwife was providing safe care undermine all the other moments? It seems the midwife picked up on the tension growing in their relationship, but Kiera did not have the courage to say she no longer trusted her knowledge. They simply continued with the tension escalating. I imagine it must have been difficult for this woman to continue with care from a midwife who was not trusted, and whose presence did not provide reassurance.

When boundaries are crossed

As discussed in the previous chapter professional boundaries are set with the intention of keeping both the woman and midwife safe by defining the edges of a professional relationship. Yet by their very term, boundaries can constrain and limit the relationship. While fixed boundaries may appeal to those who seek certainty, the reality is that the edges of boundaries can be murky. As well, women and midwives seek a reciprocal relationship and this may challenge some notions of professional boundaries (McAra-Couper et al, 2014). There are so many variables within each relationship, such as the personality of the midwife and the woman, or the setting where they meet. Then there is the midwife who lives in the same community as the women and their families that she cares for, perhaps with children who share the same schools or who attend the same activities. This means the midwife is called upon to make decisions about what is 'right' in the moment, constantly navigating ways of working with the woman that make sense, taking into account their context. This can be tricky as although flexible boundaries can enhance the relationship, they can also lead to tensions in the relationship. This section explores the experiences of midwives who experienced boundary crossings that led to tensions in the relationship.

Always excuses

While humans seek emotional connectedness (Helm, 2012), not all women seek a reciprocal relationship with the midwife.

> *One woman wouldn't come to appointments or I'd visit her at home, and she wouldn't be at home when she said. There were always excuses. She was just hard work from the get-go. She didn't participate or engage. At 34 weeks she had bad abdominal pain at 2am. The ambulance man called me. I couldn't do my full assessment*

> *because she was so reactive. She told me to keep my f'ing hands off her and to get out of her house. So, I left, and declined any further care. I felt bad because she was low socio economic and a high need sort of person (Judy, midwife).*

Judy accepted this woman did not want a close relationship with her. While it was harder for her to provide care in such circumstances, she continued trying to make the relationship work on the woman's terms. The episode of abdominal pain provided a turning point for her. 'Bad abdominal pain' needed a close and careful assessment yet Judy was not given permission to do this. How can one practice safely in such situations? Judy did not know how the woman would behave or whether she would engage when she needed her to do so. For Judy to have maintained her involvement may have given a semblance of safe care which Judy knew was absent. By withdrawing her midwifery care she made a declaration that there was no longer any degree of safe care. She left the void for the woman or others to step into, perhaps in a way that would bring the level of safety she herself had been prevented from offering.

Relationships that lack reciprocity can be hard work. The strained relationship and limited conversation make it difficult to build trust. I can only speculate as to why the woman did not want a relationship. Perhaps she had not experienced good relationships in the past. Maybe trusting the midwife required her to give up control that she did not feel safe to relinquish. Perhaps Judy was the 'wrong' midwife. In chapter five we heard from the stories from women about the difficulties and vulnerability they felt when looking for a midwife. Perhaps for this woman, it was just too hard to look any further. It takes additional time and emotional energy from the midwife to reach out to women who do not trust readily. However, doing so is important since the consequences of not trusting can be devastating, perhaps for them both (Flores & Solomon, 1998). It may be that withdrawal of the midwife's care is the best approach to such difficult relationships. Yet her inability to trust the midwife disadvantaged this woman who was now without care. It seems that, trusting relationships are part of ensuring safe care.

The midwife gets frustrated with the woman's behaviour

The midwife has a professional responsibility to provide care even if she is frustrated by the woman's behaviour. This makes it harder for her to walk away from women whose behaviour challenges the midwife's expectations of a respectful relationship.

> *I looked after this woman for all of her eight babies. She really played me off. She wouldn't come to clinic, but she wasn't home when she said she would be. By her*

> *last baby I felt like I was putting extra effort in to be pleasant and nice and to give the same level of care as I would give everyone else that I enjoy. I make sure that my quality of care, regardless of the woman's relationship to me, is the same for everyone. I don't know if she realised I was a bit sick of her behaviour. I was very relieved when I knew she'd had another baby with another provider (Annie, midwife).*

Annie had a longstanding relationship with this woman through the shared experience of her many babies. Providing care within an established relationship is something midwives usually look forward to. Both have come to know each other and have worked together to build a shared understanding of how care 'is'. The midwife may assume that the woman is happy with the care she received, and perhaps the woman feels accepted as she is. However, Annie was frustrated with the woman's behaviour and as time went on, found herself needing to 'pretend' she was engaged in the relationship. Despite her working hard to keep her quality of care the same, it seems the woman picked up on the change in how their relationship felt. I wonder whether being-with the woman can be feigned. Maybe it is the authenticity of the relationship that matters.

Annie did not feel respected within the relationship. It seemed the woman did not engage in the relationship in a way that respected what was important to this midwife. Needing to chase the woman for her appointments does not sound like a partnership. Yet despite her frustration, it seems that Annie did not feel able to tell the woman of her concerns. Why? Perhaps the behaviour had developed over time and it was too late to complain about something that had gone on for so long. Perhaps she had tried and the woman had not listened. Either way it was likely to be a difficult conversation. Perhaps the relationship was already fragile so that was something to be avoided. Yet the consequence of the behaviour was that it was an effort for this midwife to care for the woman in a way that felt authentic to the midwife, one where she could be herself (Heidegger, 1962/2008). Maybe their expectations had changed over the time they had been together, but this had not been revisited. Perhaps the woman was also aware the relationship was not working but was reluctant to move away from a relationship where they had shared so much. A conversation may have opened the way to a relationship that was healthier.

Feeling the situation is unsafe

As the health professional, the midwife is responsible for ensuring the woman understands the choices she has in any situation as well as the consequences of her decisions. However, this assumes the woman wishes to engage in conversation with the intention of a shared understanding.

We talked a lot about why she wasn't going to the clinic and she just saw it as a waste of time and hated being there. I felt like she was a ticking time bomb and she wouldn't engage, and her bloods were getting worse and worse. I didn't feel like the partnership thing was going on. Her husband was saying why can't you get her to go and I'm like well, this is your family stuff. That was hard. I was documenting furiously. I don't mind if they're informed and they don't engage. They go, that's my choice and I don't want to do it. But the ones with a small baby or with something like that. You just want to get them checked out. I'm supposed to be able to refer but they've got to agree to engage. Postnatally her BP was still high. I'd drive all the way out there and she wouldn't be home even though I'd just text her (Kelly, midwife).

The woman's pregnancy was not straight forward, and Kelly felt there was the potential for something to go wrong, perhaps causing harm to the woman and/or her baby. While they talked, they did not seem to reach a shared understanding. No matter how much she tried Kelly could not reassure herself that the woman was making an informed decision. Rather, it seemed the woman did not want to follow the midwife's advice. Perhaps the woman wanted to pretend that all was well. How does the midwife keep herself and the woman safe when the woman is making decisions she does not agree with? Of course, the risk was already there. The woman and her baby would be safe, or not. When women do not engage with other health services the midwife is left as the sole provider of care. This leaves the midwife vulnerable, particularly if the woman does not have a strong connection with her. What if something untoward happened? Who holds the responsibility in such situations? This midwife hoped that her documentation would protect her from any enquiry that might occur. The woman may have trusted Kelly to keep her safe, but it seems Kelly did not trust the woman to make good decisions. It appears partnership was out of balance in this relationship.

Despite the challenges, it seems that Kelly did not consider an exit strategy. Instead she remained in the relationship, waiting, and watching closely in the hope that she did not miss anything. The woman appeared to have little consideration of how her behaviour may impact on the midwife. Perhaps she felt unable to describe how she felt, or perhaps she held on to any semblance of control in a situation that threatened to be beyond her control. It is likely any adverse outcome would impact on Kelly emotionally and perhaps professionally. This was a woman she knew who she wanted to have the best care she could provide. Yet despite the barriers, this midwife continued to provide care in such difficult circumstances. We are left wondering what it would take for her to decline to provide care. It seems that it is difficult for the midwife to decline to provide care once the relationship is established. Yet what is the cost to the midwife by continuing to work in such a difficult and potentially abusive relationship?

The midwife doesn’t know what is happening

During the pregnancy, the midwife comes to know the woman, including her character and her life circumstances. Within some relationships the midwife can experience situations where the woman appears to be hiding something from the midwife. Somehow the midwife must continue to provide care working with the unknown.

> *I had a woman where P was involved and a bunch of other stuff. I was not sure what’s going on. There were things that didn’t add up. I was looking at a woman who was not always attending, was sometimes altered, had one kid previously taken away, and telling me things that I didn’t believe. I don’t think she trusted anybody and somehow I still have to care for her. I could not talk with her about my concerns, there was no connection, so I put in a report of concern but didn’t tell her. I think she would have run if I had that discussion at that time in her care. Once she had her baby she was amazing. She trusted me and was a good mum. To keep myself safe I was very aware and documented a lot. I think you use your intuition. It either feels right or it doesn’t (Clare, midwife).*

This woman had lots of issues going on in her life. Clare knew of some of them but sensed there was much more. There were enough red flags to concern her such as one child in state care and previous drug use. Amidst this complexity, it seemed that neither trusted the other. It may be that this woman trusted no one. Perhaps for this woman trusting the midwife could have unknown consequences. But for the midwife, knowing what to do was not simple. She expected the woman to be truthful with her. There were no rule books or guides to managing such tricky relationships. Midwives must attune to the woman and make their own path if they are to earn her trust. Clare set out to prove herself, but at the same time she made sure she kept herself safe by documenting her actions related to her concerns, being vigilant in her care and talking with others who could support the woman. Clare drew on her understanding of what might make a difference in order to gain the woman’s trust. Such relationships require the midwife to be generous with her time.

This midwife expected that a positive relationship would open the way for the woman to trust her. It seems that the complexity of the woman’s situation did not worry her as much as not knowing what else was ‘there’. This left the midwife needing to work around the gaps while remaining mindful of what she was missing. In this story the relationship became the tool that engaged the woman and enabled the midwife to provide care that mattered. Yet this assumes that this woman’s problems were something the midwife could ‘fix’. The reality is that poverty, family violence and drug and alcohol abuse affect women and their families in our communities and any ‘fixes’ are multifactorial. As the relationship developed it seemed

this woman came to trust the midwife in a way that worked for them both. Perhaps this was the first health professional who had taken time to be with her. Perhaps she was open to a relationship now because this midwife had got her safely through her pregnancy and birth and shown herself to be trustworthy. As Gadamer (2013) reminds us, "conversation is a process of coming to an understanding" (p. 403). Perhaps in being interested in what was important for this woman, Clare became someone she could trust.

The midwife finds herself in a complex situation

By working with the woman, the midwife comes to know her and her family. There may be times when the midwife finds family dynamics that are complex, and these can have repercussions on their relationship.

> *A couple of weeks after the birth the woman's husband rang me in tears and hysterics. I thought something really bad was going on. He said she was threatening to leave him with the baby and never come back. I went and saw them. She was talking very strange and crazy and I thought she might have postpartum psychosis. I was genuinely worried for her wellbeing, but her husband said no, we are alright. He could have been an abusive husband, and I'm still not sure that he wasn't. I weighed the baby and did everything for those last two weeks, but I felt like the partnership was gone. I thought you pushed me over the edge there. They told their doctor how wonderful I was. But there were so many calls and so many incidents of them not taking responsibility throughout. I couldn't provide care to them again (Rose, midwife).*

This story shows how the woman's family can influence the relationship the midwife has with the woman. It seems there were other episodes of behaviour that worried this midwife. But it was this one that was the final straw. This husband pulled the midwife into family dynamics that she did not understand, and this left her feeling uncertain and out of her depth. She did not know if the woman was safe and worried about what she might be missing. Midwives are 'tuned' to what the relationship feels like and this one did not feel 'right'. In the aftermath of the event, Rose felt she was going through the motions of care rather than giving care that felt authentic. She found she no longer trusted the woman and in turn, no longer enjoyed the relationship. Such relationships call on the midwife to be on high alert to that which she cannot see but which she is aware of.

It seems that the relationship between the woman and the midwife was undermined by the husband's behaviour, and this was something the woman had little or no influence over. Rose was relieved to finish the relationship. The calls and incidents had eroded Rose's trust in the woman and her family. It seems there was more going on in this situation than the

midwife could name. She strongly suspected a mental health issue. She wondered if the husband was abusing his wife but had no proof. There were too many tense moments that left her feeling vulnerable and at risk. It was not a situation she wished to put herself in again. Despite the events, it seems the woman was happy with Rose's care. Perhaps she had no insight into how her behaviour affected the midwife. Perhaps she had a different understanding of the midwife's role. Perhaps she was grateful for the midwife's support during a challenging time.

Struggling with the woman's life choices

It can be difficult for midwives to support the woman's life choices when this ignores the evidence as to how to keep her and her baby safe.

> *I cared for a woman who drank alcohol and smoked during her pregnancy. She would miss appointments, then not be home when I visited. Everything was hard with her. She breastfed for 10 days then she put the baby on the bottle. She said she had to have her alcohol every Saturday and I could not change her mind. I asked her if she wanted another midwife, but she said no, I want you. Then she phoned me less than a year later to say she was pregnant again. I could not put myself through that whole pregnancy again (Carol midwife).*

Everything this woman did seemed to challenge the midwife. She missed appointments and was not home when the midwife went to see her. She continued to drink and smoke. What is the midwife to do when the woman ignores her advice? The midwife could see the risk, but it seemed the woman could not. I wonder was she too 'nice', perhaps making suggestions in partnership with a woman who did not understand her role. The midwifery philosophy is that the midwifery partnership is women-centred with the woman focused on herself and her baby (Guilliland & Pairman, 2010a). Yet it seems this woman was not considering the wellbeing of her baby, or certainly not in a way that resonated with Carol. It seems the way she cared for her baby did not reflect this midwife's expectation of a 'good' mother who was wise and responsible. It may be that this woman had little control over anything in her life and did not expect anything more. I imagine it would be frustrating for the midwife, not knowing how to make a difference, watching for the consequences that may unfold.

This midwife decided she had provided care to the woman as best she could once, but that was enough. She would not compromise herself another time. Yet it seems the woman trusted Carol. We do not know what was happening for this woman at this time. It seems likely there were addiction issues present. Pregnancy and childbirth are times of significant change in women's lives. Perhaps this woman was ready to engage in a relationship this

pregnancy. I remember Skinner (1999) who asked whether the partnership model only worked for the white, well, educated woman. This woman needed care but was now left looking for a midwife because of her previous behaviour. I wonder what skills would support midwives to work with women who resist a relationship. Yet for the midwife to continue in this relationship left her vulnerable to any negative outcomes, including things such as reputational damage from the 'they, or an investigation. It seems that in choosing not to care for her another time, this midwife was protecting herself.

The midwife chooses not to take a particular woman

Midwives in this study revealed that the initial phone call was an important decision point for them. It was at this time that they decided if they wanted to care for the particular woman.

> *I said no to a few women. If I looked after them before and they were a nightmare - texting or phoning constantly with non-urgent or annoying rubbish, lots of social issues that required huge amounts of my time. There were a handful I said I was full for because I just got a 'vibe' on the phone that they would be a nightmare... sometimes you just know (Heather, midwife).*

Like Carol in the previous story, Heather declined to care for a woman she had not enjoyed caring for previously. But even women who sounded like they could be a problem were declined. Her 'polite' way of saying 'no' was to tell the woman that she was full for that month. Whether the woman knew it or not, she had behaved in a way that crossed a boundary set by the midwife. Remember in chapter five, when women described how they found the 'rules' difficult to understand and at times challenging to implement. Perhaps trying to understand the 'rules' made the difference. But what if the woman has no understanding how her behaviour affects the midwife. What if they have little knowledge of the professional relationship? I wonder also if women understand what to expect from midwifery care. It seems there is a disconnect between what some women and midwives think is acceptable behaviour within a caring relationship. Of course, if the midwife does not discuss her concerns, the woman has no opportunity to address her behaviour. Regardless, the consequence for the woman is that it is now harder for her to access midwifery care.

Due to an ongoing shortage of caseloading midwives in many areas of Aotearoa New Zealand, the midwife can usually choose which women she will care for. The current payment structure means there is little additional payment for the woman who needs extra care and support due to obstetric or social complexity, or the woman who is hard to find. The woman who takes up 'extra time' can encroach on the midwife's own time, perhaps leaving

her feeling overwhelmed by these unexpected demands. Heather's experience of working with women with similar circumstances gave her an understanding that the requirements of caring for such women may overwhelm her. Declining to care for women who demand 'too much' sits uncomfortably with the woman centred philosophy of midwifery care. Perhaps it is this that makes midwives reluctant to tell women their demands are 'too much'. Or perhaps they do but the woman does not change her behaviour. Or could it be that these demands become 'too much' in the absence of a positive relationship? It may be that the easiest time to back away from a relationship is before it has become a formal agreement. In declining to provide care, the midwife is 'leaping ahead' to care for herself in a way that ensures her practice is sustainable.

Working with tensions in the relationship

Caseloading midwives in this study described working with tensions in the relationship. Sometimes a way through was found, while sometimes they accepted that was how the relationship was and worked with it on the woman's terms. At times, women were also aware of tensions. This section explores the experience of when the midwife and the woman were able to work through the tensions that arose.

When the midwife does not feel trusted

It can take time for the woman and perhaps her family, to know if they can trust the midwife. It may be that before she can be trusted, the midwife must show that she is trustworthy.

> *The woman had a scar on her abdomen. I asked her to tell me about it, but her mum said, it's self-harming and she doesn't do it anymore. The woman didn't say anything. I had to wait ages till her mum trusted me enough to be alone with the woman. Then she didn't show for two appointments. I rang her and sent her a letter saying if I don't hear from you by a certain date, I will assume you've found another midwife. She rang me immediately and came to the next appointment. I said, shall we talk about your birth, just in case I don't see you for a while. We're sort of grinning at each other. I had to change my style, and in the end, she goes, that was choice, I'll see you next week. She was awesome (Kelly, midwife).*

There were things in the woman's background that the woman and her mother were not ready to share with the midwife. It may be that the family had experiences that led them to be cautious about trusting health professionals. Flores & Solomon (1998) suggest that to trust entails a "lack of control, in that some power is transferred or given up to the person who is trusted" (p. 206). Perhaps the only way the mother knew to protect her daughter was to maintain control of the information she shared with this midwife who was not yet known to

them. It may be that at each appointment the midwife must show that she is trustworthy. Over time as she demonstrates that she is reliable, she is non-judgemental, that she knows what she is doing, and that she cares, she can build trust. The midwife was not trusted just because of her role. For this woman it was going to take time to for her to know if she could trust this midwife for herself. Thus, Kelly had to allow for time to earn their trust.

When the mother stopped attending the appointments Kelly felt she had earned her confidence. Of course, it may be that other priorities prevented the mother from coming. Then the woman stopped attending. Kelly issued a challenge to the woman to either attend or she would assume the woman would find another midwife. When the woman attended Kelly recognised she needed to change how she interacted with her so that she could feel a connection with the woman as a person. Her different approach paid off. It seems there was more spontaneity in their conversation and a playfulness between them that brought about a change of mood. So much so that the woman indicated she would see this midwife again the following week. Attunement was important for both the woman and the midwife to be able to engage in a relationship. Perhaps feeling attuned opened the way to conversation that flowed which in turn led to them feeling a connection.

Struggling with the personalities

Deb describes a situation that impacted on her as the midwife when she did not feel trusted. The experience left her feeling drained and not wanting to work with the woman again. Yet despite this, when asked to provide midwifery care for their second birth she agreed. Yet the second time around the relationship was completely different.

> *There was a dad who drove me nuts from the first time I met him. Every time they left clinic, I got a headache. I just felt like what am I doing this for. He kept pacing in labour and in the end, I sent him out. I said you need to go and come back in a couple of hours. Just go for a walk, calm down because she's not going to labour if you behave like this around her. Which he did. When they finished, I was never so glad to see the back of a couple in my life. He was just so intense, and I felt untrusted. But he was just anxious. They rang me to look after them the second time, and inside my head I'm going, say no, but I said yes! He was completely different the second time round. I'd got his wife through pregnancy and delivered safely, so this time round the reins were mine (Deb, midwife).*

Caring for this woman included also caring for her partner. Doing so meant it was a three-way relationship, with the partner's needs included as part of the midwife's care. Responding to his ongoing concerns was hard work for the midwife as she sought to gain his confidence

and understand his concerns as well as those of the woman. The way he engaged in the relationship left Deb feeling untrusted and doubting that she would care for them again. But I wonder whether the relationship sustained her despite the difficulties. Or perhaps it was knowing the woman that made it harder to decline her request for care. Fortunately, the second care experience was very different. It may be that until the midwife is 'tested', the woman cannot be sure how the midwife will respond. Whether the midwife cared for her and was responsive to her concerns? Whether they were safe? Perhaps it is only in hindsight that the woman and her family know for sure that their trust in the midwife was well founded. For some women giving up control to trust the midwife may be a step too far until the midwife has proven herself. For the midwife it is a leap of faith that the relationship may be better.

The concept of partnership as woman-centred is tested by this story. Of course, the woman's family and friends have always been there for her, but in this situation the midwife was required to 'care' for the woman and her partner. Perhaps it was him who was anxious and required reassurance. Perhaps it was he who needed to understand normal birth. By meeting his needs, he could then stand back and trust the midwife to care for the woman. If he was reassured, then it is likely the woman was also. While midwifery is woman-centred it is also inclusive of those recognised by the woman as being important to her and who she determines need to be included. However, this story shows the extent that this can impact on the midwife's work. Yet in proving herself, this midwife felt trusted to provide care that was right.

When the midwife feels out of her depth

Social complexity impacts on the caseloading midwife's work. When situations arise that challenge the midwife to know how to best to support the woman, she may feel overwhelmed.

> *I cared for a woman who was a late booker and a non-attender. I went to her house for a postnatal visit and she told me what was going on. She had a restraining order on her partner, but he didn't listen to that. She was living with her sister and brother in law and sometimes so was he. She had huddled in one of the bedrooms with her children with the door wired shut. I rang the agencies for help but they did not see it as urgent. I was frightened for her. I felt out of my depth and I didn't know how to fix it (Clare, midwife).*

This woman had a lot going on in her life. While Clare may have had suspicions that something was not right, it was only when she went to the woman's house that her reality

was revealed. There were so many aspects of this situation that were frightening for Clare. Of course, the risk had always been there but now Clare knew about it. She did not know where to start or what to do to help. Clare expected the social service agencies would be supportive but felt that they were not. It seems that both had little control over the things that were happening in this woman's life. The government has passed laws and set up programmes to reduce family violence. Yet this midwife could not find a service to support this woman now, because her situation was not deemed urgent. A society is measured by how they care for their vulnerable, however it seems this woman was left to sort her situation with support from her family and little else. What is a midwife expected to do in such situations? Her care ends at six weeks, yet this woman had to continue to live with her circumstances.

In getting to know women over their pregnancy journey and by visiting them in their homes, midwives are more likely to come to know the reality of the woman's life. This story is similar to many that I have heard or experienced over the years. The impact of family violence is well documented. I wonder why it is the woman and her children who are 'taken away' and have their lives upended. But what about the midwife? I wonder if witnessing the challenges that some women live with results in trauma to the midwife. The fear that surrounds some women as they carefully live their lives is unsettling for the midwife to witness. As well, there are women who refuse to walk away from those who hurt them, causing the midwife to be fearful for their wellbeing. We know that continued exposure to other people's trauma can lead to compassion fatigue or vicarious trauma (Davies & Coldridge, 2015). I wonder how midwives sustain themselves in such challenging situations.

Tension in keeping the baby safe

The midwife-woman relationship assumes that the mother is the best person to determine the care her baby requires. However, there are times when the midwife must leap in to ensure the baby and mother are safe.

> *One woman said to me, you cannot tell my husband what I'm going to tell you. She said I've picked up my baby and spoke to him roughly. She'd done it on more than one occasion. She did not want me to tell her husband but that was a line I had to step over. I said you've told me that your baby's at risk. I don't think you're a terrible person and I think you've been very courageous to tell me this and we will work our way through this. However, my first duty is to make sure that your child is safe now and we need to put things in place (Rose, midwife).*

This woman asked the midwife for help when she recognised that her baby was at risk from herself. To do so required a leap of faith that the midwife would respond in a way that was supportive. The woman could not know how Rose would respond, but her attunement with the midwife may have given her confidence that she would be safe in her disclosure. It may be that when the woman knows the midwife, she is more confident to disclose a difficult situation to her. On the other hand, she may worry about letting the midwife down by not being a 'good' mother. Perhaps she trusts that the midwife will respond in a way that considers what is in her and her baby's best interests. Such conversations take courage for the woman to share her concerns, and the midwife to respond appropriately. Perhaps by acknowledging the woman's bravery in sharing what had happened and by reassuring her that they would work through this together, this woman felt supported.

It is likely that the midwife's response would influence how their relationship played out in the future. Whether the woman felt accepted or judged by her behaviour. Whether the midwife was responsive and could offer real support. The midwife's response may also determine the baby's wellbeing. For example, if she did not take the woman's disclosure seriously what risk might remain for the baby, or the woman going forward? When women share sensitive information the midwife has a professional responsibility to respond and this may include mandatory notification to child protection services. Such situations call on midwives to draw on their professional responsibilities using strong communication skills to navigate through circumstances that may be tricky. Neither can foresee where their conversations and actions may lead. On the other hand, what happens if the midwife privileges the relationship over the safety of the mother and baby? Perhaps the midwife does not want to upset the woman or shies away from difficult conversations. It may be that the positive relationship opens the way for such difficult conversations and supports the woman through difficult circumstances allowing her and her baby to be safe.

Tension in keeping the woman safe

Sometimes the midwife can only watch while the woman lives her life in a way that may be detrimental to her health, wondering how she keeps her safe.

> *I cared for a woman who was really open. The stuff that falls off her tongue was different to me in my little cocoon. There was a lot of drama in her life. She rocked up either dressed to the nines in heels and looking amazing or she was covered in cow shit. Two days after her caesarean she was mowing the lawns. She got home and they were long, and she couldn't cope with it. I couldn't get her to stop no matter what I did. She's pregnant again and most of our visit is her venting with a short bit on all*

the physical problems. She stands out because I really enjoy her, and I always look forward to our appointments (Kelly, midwife).

Kelly enjoyed the relationship with this woman who told colourful stories, was dramatic and at times chaotic. But she was also unpredictable and pushed the boundaries in what she should do. While the midwife could offer advice and caution the woman about her decisions, it was clear that this woman made her own decisions. There is a sense the midwife was fascinated by how this woman lived her life. In listening to the woman, the midwife gave the time and the space for the woman to be heard. It appears that she accepted the woman for who she was. Heidegger used the concept of a clearing in a forest, where the light is brighter while surrounded by the darkness of the forest (Harman, 2007) to describe how Dasein can see, or gain understanding. As the woman talked about her life the midwife gained insights into her as a person. Perhaps the woman also gained a deeper understanding of herself. Being accepted for who she was, regardless of how she presented herself may have been an empowering experience for this woman.

Mowing the lawns two days after her caesarean is not part of any postoperative care plan. I wonder what circumstances led this woman to see this as something she needed to do. Where were her family and friends? We do not know what her circumstances were or how she came to see such behaviour as appropriate. There is a sense that the midwife struggled to know just what to do, whether to leap in or to stand back. It was not the midwife's job to mow the lawns, but it was not appropriate for the woman to be doing them either. Being the midwife when the woman appears isolated can place additional demands on the midwife within the relationship. When the need is evident in front of the midwife it can be very hard for her to turn away. Yet if she leaps in what expectations does this create for the relationship, or for other relationships? Such actions are unlikely to be sustainable for the midwife.

Tension when the woman makes decision that is considered medically unsafe

Sometimes the midwife is stretched by the woman's decision. In supporting her, the midwife must work to manage her own concerns and to keep herself and the woman safe.

I've delivered all of this woman's babies and for one of them she decided not to follow medical advice. That was a hard one because she really knows her body and I trust her decision making. But there's the professional side of it. I didn't feel I could encroach on her decisions and be the bossy midwife. I didn't think she would ever take me to the cleaners because she knew her own mind. When she'd rung me to say she'd gone home I remember thinking what do I do with this? Potentially she's

> *put herself in danger, but I have to respect she knows what she's doing. I drove to the house and sat with them both and said, knowing you for this long I respect your decisions. I know that you have the best interests at heart, and I know you would have read everything there is to read about this. I know that this is not just a glib decision you've made. That's me supporting you as a person that's got to know you over all these years. However, professionally I have to advise you that what you're doing isn't considered medically safe. I will support you to keep you safe. But I have to write in here that this is your choice and when you re-read these notes later, you need to know that this is keeping me safe in the same way that you are keeping you safe. Because this is my job (Deb, midwife).*

Deb and the woman had built a trusting relationship through several births over many years. They had a way of working together they enjoyed and trusted each other. But now this midwife was pulled between her responsibilities. Firstly, to keep the woman and her baby safe, but also to keep herself safe. She felt she knew this woman well and rationalised that she could trust her decision making. But what if it all went wrong? What would the impact be on their relationship? Or on her practice? She thought she could trust the woman, but what if she could not? The woman may have been wrong, and she and her baby may have become unwell. Talking through the situation helped Deb to gain an understanding of why this was the 'right' decision for this woman. Perhaps their conversation also helped the woman as she sought to find a way through an experience she had not had before. It is likely that their established relationship supported them to understand each other in a way that would not be possible if they did not know each other. Such conversations may not be easy but are part of reaching a shared understanding.

Differences in care plans can create tension to the midwife-woman relationship. The midwife may assume her plan of care is the safest. The woman may feel otherwise. In the midwifery partnership it is expected that both bring their expertise to the relationship to negotiate informed decision making (Guilliland & Pairman, 2010a). But what happens if the midwife does not trust the woman? Or does not respect her decision making? In this story both went forward on the pregnancy journey not knowing what lay ahead but trusting each other to get through. I wonder what pressure the woman felt as she exerted her autonomy. Jenkinson, Kruske & Kildea (2017) suggest that women can feel pressured into accepting recommended care. I wonder how the relationship may have fared had the birth not turned out well. Or if the midwife not been able to keep them safe. I do not know if the midwife lay awake wondering 'what if'. Or the woman worried about her decision that took her outside of medical advice. Keeping safe is not straightforward, even in a trusting relationship.

There was one thing

Jane felt she trusted her midwife, but there was a moment when she wondered if she was right to do so.

> *When I was in labour, I didn't want to be one of those people who rang before it was time, but I did. It was 8 in the morning and she was half asleep because she'd just laboured all that night. I felt terrible because I said I wouldn't ring before I was 3-4 minutes apart. But I'd been having contractions for almost 24 hours and they were all over the show because he was posterior. She said I know it sucks but you just have to wait it out. I got to 11 and said I need you to come and check. I wanted that comfort and to know that things were tracking well. That story came to mind where I wondered if she was not wanting me to go to the hospital. I did trust her, but I did not. She needed her rest, but I needed to know I what was happening. I was miserable and tired and in pain. She had told me if you can talk through your contractions, then I know you're not that close. I remember having one and I milked it to trick her. She gave me the support I needed but I just needed to wait a little bit longer. We met at the birth centre and he was born a couple of hours later. It was still a great birth experience despite that one thing (Jane, woman).*

Jane thought she knew what to expect in her labour, but once labour started, she was not so sure anymore. She tried to accommodate the midwife's need to sleep, but she needed support. She remembered stories she had heard and wondered if her trust that the midwife would be 'there' for her was misplaced. *They* had told her about midwives not supporting women in some situations (Heidegger, 1962/2008). She did not know if she needed to go to the hospital for the drugs. Maybe she was not even in labour. How did she know that all was well? Eventually her own need overcame her desire to look after the midwife. Jane worked out a way to get the midwife's attention by exaggerating her contractions.

Her decision to call the midwife again was vindicated by her birth soon after. However, with a baby in a posterior position the midwife would be aware that it may not have gone this way. In doing 'nothing' it is likely that the midwife did something important for Jane. The additional labour time probably enabled her baby to rotate to a better birth position supporting her to achieve the normal birth she desired. In each labour and birth there is unknown and uncertainty as to how it will play out. Despite the 'one thing', Jane regarded her birth as a great experience. Yet how might the relationship have fared had the birth not gone so well? Trust is described as "an ongoing process that must be initiated, maintained, sometimes restored and continuously authenticated" (Flores & Solomon, 1998, p. 206). The midwife was 'there' for Jane when she needed her the most, thus restoring the trust that had developed over the pregnancy journey.

Trust in flux

Trust is not static. Due to pregnancy complications, Jo had a distance to travel to birth in another town. The midwife she had met was on her days off and this meant her care was from her backup who she had not met. In the beginning their communication was off.

> *My second birth was incredibly healing. But our communication was off and that definitely put pressure on the relationship. I called and said I'm coming through and she said just because your waters have broken doesn't mean everything's going to progress quickly. I said to her I don't know how quickly I'm going to progress, and I know every labour is different, but I don't like the uncertainty. And I don't want to be this far away if things get ramped up. Then I'm on the phone, lifting myself off the car seat saying we're going straight to the hospital, you need to meet us there! Her actual processes were evident, and I felt really good about that. I'm sure I did thank her at the end for certain things that she did that I noticed. Things like the placement of her hands while he was coming out so that there was no tearing. All of those things were really well done. At the end I felt this worked out for the best because she definitely felt like the right person (Jo, woman).*

Jo was anxious about living so far from the hospital and about the uncertainty of what might happen during the long drive. This was a big decision to make over the telephone. The midwife was 'right' in cautioning the woman from rushing in just because her waters had broken, yet had this woman stayed at home the midwife could have been proved horribly wrong. The woman was 'right' to drive in 'now', but she could have got there and not been in labour. In other words, there is often no 'right' answer until later. So how do midwives and women work through this conundrum? As the birth progressed it became evident to Jo and the midwife that they could trust each other. Jo had arrived at the 'right' time and the midwife provided care that was 'right' to Jo. It may be only in hindsight that the woman is able to realise that she was right to trust the midwife.

Conclusion

This chapter show the importance of trust in the professional relationship. Midwives are attuned to what the relationship feels like, and in particular, whether trust is present. Midwives came to the relationship with an expectation that the woman would be open about things that may impact on her or her baby's wellbeing. The midwives expected the women to be truthful, but some women were not ready to trust a midwife who was unknown and as yet unproven. When the woman did not share relevant information the midwife had to interpret what was happening, drawing her understanding from the woman's behaviour, and building on what she already knew. The unknown led the midwife to feel uncertain about whether she could trust the woman and what consequences there may be ahead, perhaps for them both. Midwives described avoiding relationships where

they struggled to understand what was important to the woman, or where boundaries were repeatedly breached. The absence of trust brings about tension in the relationship.

Relationships are contextual. For some they are against a background of poverty, family violence, or perhaps an anxious family. Those who have a low capacity to trust are less likely to enter relationships and do not expect anything positive from these (Hardin, 2002). However, positive experiences can counter such understanding. The midwives described how they continued with tensions in the relationship in the hope that it would improve. Some described engaging with difficult conversations to find a way forward. This required both to be courageous to face up to their concerns. While some relationships came to feel 'right', others did not. Sometimes trust grew toward the end of care, perhaps because the midwife had proven herself by getting the woman safely through her childbearing journey, or the woman because nothing untoward occurred. The women's stories showed how trust was threatened when the midwife was not attuned to what was important to her. A relationship that was eroded by a lack of trust did not feel safe to the woman or the midwife. Trust is not a given. Rather it is won and lost as the relationship plays out. The next chapter will explore the experience of relationships that go well.

Chapter 8: When the relationship goes well

Introduction

Providing care during the pregnancy enables the midwife and woman to get to know one another over a period of time. This gives them the opportunity to engage in meaningful conversation and through their discussion develop a deeper shared understanding. In this way, the midwife comes to know the woman as a person and to learn what is important for her and her family. Studies show that women prefer continuity of care because of the opportunity to build a relationship with someone who knows them (Dahlberg & Aune, 2012; Forster et al, 2016; Sandall et al, 2016). All women in Aotearoa New Zealand have access to continuity of care, and most relationships go well. When the relationship goes well, the woman is likely to be more confident about her birth and the unknown that lies ahead. But what does such a relationship feel like? This chapter will explore the experience of the study participants when the relationship went well. It considers the attributes that the woman and midwife bring to such relationships and the woman's sense of loss at the end of the relationship.

Trust

Flores & Solomon (1998) describe trust as a "dynamic aspect of human relationships" (p. 206). Trust requires continual maintenance to flourish through ongoing conversation and the development of understanding between those involved (Flores & Solomon, 1998). To trust is to take a risk, since trusting another involves giving up some control to the person who is trusted (Flores & Solomon, 1998). When the midwife shows that she values the relationship she contributes to the development of trust on the basis that what is important to the woman is also important to the midwife. To trust "opens up possibilities in a relationship which would be impossible without it" (Flores & Solomon, 1998, p. 209). Perhaps this is why the women participants in this study described having greater confidence in their ability to birth and to mother their baby when they experienced a trusting relationship. This section will explore what trust feels like within the relationship.

Trust begins with hearing

Conversations support the development of understanding. We use language to express what we feel, yet our understanding of what is said goes beyond the words that have been spoken (Gadamer, 2013). The words we use, the tone of voice, and our body language all contribute

to communicating what we feel and how we understand. Listening is so important for it is by being heard that we come to feel we are understood.

> *My midwife was good at listening to me. We'd have up to an hour for appointments and we'd talk about other things. I knew she was going on holiday, and she knew things about me. I would share my concerns. She made me feel confident that everything was normal. I don't remember ever saying exactly what I wanted. She just kind of fit the bill for me. She had that motherly manner that I felt reassured and confident. I wanted to enjoy seeing her. There's a lot of fluffiness with me in that I want to know that I am in safe hands and that there is time for conversation. It makes me feel secure and comfortable and you get to know the other person, rather than being this clinical tick box (Jane, woman).*

Time to chat was important to Jane. It showed her something of who the midwife was as a person, and it gave her the opportunity to share what was important to her. Chatting also created a mood that reassured her all was well, perhaps because they could talk in a way that felt free. It was important for this woman to 'know' something about the midwife as a person and their chat allowed this. Their conversation also provided the midwife with an understanding of how she could provide care that mattered to Jane. Of course, the midwife could not know what Jane's exact wishes were for every possibility. More likely, the midwife drew on her knowledge of working with women to plan care that she believed would meet Jane's need. Through their conversations, this midwife was then better placed to read what was important to Jane and respond in a way that was indeed, 'right' for her. Such attentiveness and responsiveness reassured Jane that the midwife cared about her and was someone she could trust. However, maintaining that trust was dependent on the midwife remaining attentive to what was important for Jane.

Jane enjoyed being-with the midwife. Their conversations were about more than just her pregnancy. They talked about what was happening in her life, and about aspects of the midwife's life. Determining what to discuss and to share requires 'tact' by the midwife, since what is 'right' will vary in each relationship (Gadamer, 2013). This can be tricky to get right, for it is about knowing 'something' about the midwife, but not so much as to remove the focus from the woman. The midwife's 'motherly manner' reassured Jane that this midwife had her best interests at heart, perhaps like a mother's care and concern. Perhaps in feeling nurtured the woman is stronger to respond to the demands placed on her during her birthing journey. It seems that enjoying being-with was part of developing a trusting relationship for this woman. I wonder, how the relationship would have fared if this woman did not enjoy her time with the midwife. Would she have trusted so easily? When the midwife is attentive and responsive, that is, she is attuned to the woman, they are more likely to develop a trusting

relationship. Being attuned to the relationship means the midwife is constantly checking with the woman about her assumptions (Flores & Solomon, 1998). In doing so, the midwife is likely to get it 'right'.

Finding things in common

Like Jane, Maisie found getting to know the midwife as a person strengthened their relationship. When the midwife shared that her mother had also died it made the relationship stronger.

> *The time during the pregnancy was easy. We'd talk through the medical stuff and how I was feeling. Then there was chat about general stuff. Just work and her life and my life and all that sort of stuff. It felt like you were talking to a friend as opposed to talking to a medical professional. We had in common the fact that she had lost her mum and I had lost my mum. She let me in to some of her personal life without being too much. It wasn't just about the baby and the pregnancy (Maisie, woman).*

Feeling cared for is a complex phenomenon. Maisie had time to chat with the midwife about her pregnancy and also about things outside of her pregnancy. The time to chat let Maisie be herself and in doing so, what was important to her was revealed to the midwife. Speech is described as the "articulation of understanding, but this articulation doesn't first happen when we try to say what we feel" (Gendlin, 1978, p. 3). Rather, it takes time. In the back and forth of conversation Maisie came to feel close to the midwife, almost like she was a friend. Someone she could confide in, someone she could trust. Yet Maisie was aware that the relationship was not a friendship. She did not want the midwife to share 'too much'. In the play of conversation, this midwife got the balance 'right' since her sharing gave Maisie confidence that she cared about her. Of course, had the midwife not continued with the 'medical stuff' and to check how she was feeling, Maisie may not have felt so cared for. But this combined with the chat about 'general stuff' helped Maisie to feel the midwife knew her and cared about her. That their relationship was more than just another pregnancy.

Trust opens up the issues

When the midwife knows the woman, she is more likely to pick up on subtle changes in her mood. But it is only when the midwife is trusted that the woman may share what really concerns her. Opening the conversation gave Clare the chance to build trust with this woman.

> *I noticed the woman's mood was low, so I asked her if she had any concerns and she said not really. I said that doesn't sound very convincing! She talked about how she didn't feel she was listened to last time. She felt she was in labour, they didn't*

> *believe she was, then boom, she was pushing. I said I promise that will not happen because you will ring me and say you're in labour and we will go, because I trust you know what you're doing. Some women find it difficult to communicate their emotions. Not everybody is going to open up or even know how to verbalise it, whether they trust you or not. Because I opened it up for her, she did share. My job satisfaction comes from picking up on cues and being open to my intuition (Clare, midwife).*

Being attuned allowed this midwife to open the conversation with the woman. Clare noticed that something was not right. Such noticing was important to her and to the woman. While words enable us to communicate, they do not always convey the full meaning of our understanding. Claire recognised that what was said told only part of the story and probed further by asking questions and considering the woman's response. This back and forth question and answer explored the woman's feelings, and in doing so uncovered assumptions that perhaps the woman was not fully aware of or had not realised were important. Such conversations take time, time to talk and time to reflect on what was said. And perhaps courage from the midwife to open up what is not yet known.

There was a tension in bringing the mood into the open. This woman had felt let down in the past. What if this midwife was no different? When the midwife noticed her hesitation and asked again, the woman may have been reassured that this midwife was sincere in her desire to know. After all, she had heard her hesitation. It is likely the midwife would have got it wrong had she tried to guess the reason for the woman's mood. Such assumptions can undermine the trust that this midwife sought to build. When Clare knew what was important to this woman, she was able to make a plan to reassure her that she would be 'there' for the woman when she needed her. Her sincerity likely reassured the woman. Nevertheless, the woman may have wondered as her labour drew nearer, whether this midwife would be 'there' like she said she would. Midwives are attuned to such promises they have made in particular, because trust is created by promises that are made and kept (Flores & Solomon, 1998). Of course, there was the possibility that the woman would call too soon, and they may need to wait for the birth. Such is the reality of responding to the woman's vulnerability.

Trust does not rush

There are situations where the woman may need to trust the midwife quickly, perhaps in care situations where they have only just met. In these contexts, the woman may trust the midwife due to her professional status. When the woman has time to know the midwife she comes to 'know' if the midwife is someone she can depend on. Trust is described as an

“attitude, a feeling, an emotion” (Flores & Solomon, 1998, p. 208). We trust someone because we come to know their character within a relationship.

> *I never felt rushed. She took really good notes, not just a list of things that we talked about. She included things that were important to me, like my last week of work. We talked about things that I needed to think about, like referring for blood tests and telling me the results quickly, and then what options I had. Having the time to talk about more than just what’s going on in the pregnancy is the only way to build trust and confidence, and to then feel more confident going into birth knowing that you really trust the midwife. Knowing I can trust the midwife helped me to be calm and relaxed. I knew that I could ask my midwife anything and not be perceived as being stupid. I knew I could call in early labour, and she would come. There was no judgement. It built my confidence, rather than looking to her for what I should do. She made me feel like what I’d done was ‘absolutely perfect’. For me, language is so powerful. Just because you’re not doing what everybody else is doing, doesn’t mean it’s not normal. Through our conversations I knew her first priority was safe delivery of the baby and my safety (Milly, woman).*

Milly noticed the midwife’s care. She took good notes, she shared results quickly, and she looked ahead to what might happen so that Milly could feel prepared. She shared her knowledge in such a way that grew Milly’s confidence in her own knowing. She noticed what was important to Milly. Her notes were not just a clinical record of what had happened, but they also captured the social events that occurred along the way. While they talked about many things, the midwife also continued to do those things that were important to her. In leaping ahead this midwife enabled Milly to come to understand what she was capable of. Their conversations reassured her that the midwife would be ‘there’ for her should she be concerned about anything. This nearness is not measured on physical proximity but on the availability of the midwife. That is, Milly trusted the midwife to respond to her if she called.

This midwife created a space for her and Milly to be together. The feeling of not being rushed was special. It seems her time with the midwife was not measured by the linear passing of the clock but by the temporality of time (Heidegger, 1962/2008). While the midwife’s day is structured around the requirements of the women she cares for, within their appointment this midwife created something different. Perhaps it was stopping to talk. Maybe it was the breadth of knowledge shared by the midwife that was fascinating for Milly. Or perhaps it was the uncovering of Milly’s own knowing and confidence that made the time so immaterial. In a time constrained environment, it can be hard for the midwife and the woman to hold such spaces. Yet the time to sit and be together was important to allow a shared understanding to build. It seems that Milly was open to learning and this midwife shared information in a way that met Milly’s needs. Their time together enabled them to

develop a deep understanding and in turn, to build a trusting relationship. It was this trust that helped her to feel calm and confident about her own abilities, perhaps because she had this midwife with her. I wonder if this midwife was not available on the day she birthed whether this confidence would remain if care was from the back-up midwife.

Trust can be transferable

During her pregnancy, the woman comes to know the midwife. She may meet the backup midwife as part of the planning for her birth, or they may not meet unless her care is required. Either way, it is likely the woman knows the backup midwife by name and perhaps by recommendation. This would support a mood of confidence that the backup midwife was someone she could trust.

> *Because of the growth in relationship I really wanted my midwife. I think that because I trusted the midwife, I trusted her partner too. You want to hope she chooses the right partner! They're obviously not the same people but I didn't feel uncomfortable with her at all. I trusted her so much I was okay with those people she was delegating to. I trusted that my main midwife was still providing most of the things. I didn't mind the other people because I felt like she would still be around. She wasn't ditching me. She's got other people to care for as well (Stella, woman).*

There are situations when trust is transferrable. The midwife was known to Stella and had shown herself to be someone she could trust. Because of their relationship, Stella's preference was that this midwife would provide her care. However, she accepted that there were times when this midwife would not be available. Perhaps Stella trusted readily, or maybe the midwife had reassured her about the qualities of her colleagues. Even so, Stella considered the significance of the midwife having a partner who was 'right'. But what was 'right'? Maybe it was someone who worked in a way that was similar to how she had experienced care with her known midwife. Maybe it was someone who shared similar values to her midwife. Perhaps it was the ability to engage in a relationship with her. Such attributes would probably make the backup midwife likeable to the woman, particularly at a time when she was seeking care and thus, vulnerable. It seems that trusting the known midwife made it easier to trust those she chose to work with.

Stella was reassured that the midwife retained an overview of what was happening to her, even if she could not be there at that time. This meant the midwife was 'there' for her if she needed her. The backup midwife will usually receive information from the known midwife to inform her care for the woman. However, each midwife has their own character and ways of engaging in relationships. I wonder if a different approach puts the trust that has been

established at risk of being eroded. Trust is maintained through conversation, “by way of commitments…(and) explicit and tacit understandings” (Flores & Solomon, 1998, p. 218). Hence, there is the possibility that the introduction of someone new to provide care may create tension in the relationship the woman has with the first midwife. The backup may be easier to get along with, or not. Not feeling “uncomfortable” with the backup midwife suggests there was not such a positive relationship. Yet for this woman, her relationship and trust in the midwife were justified. The backup midwife met her needs and she remained confident in the care provided by her midwife. Even so, trust should not be “taken for granted” (Flores & Solomon, 1998, p. 218).

I felt really cared for

Birth is a time when the woman is vulnerable (Briscoe, Lavender & McGowan, 2016). In part because she is exposed physically and emotionally to the demands inherent in the act of giving birth. But also because it is a time of uncertainty that brings about a significant change to her life circumstances. She becomes a mother and usually becomes responsible for the wellbeing of her baby. The women in this study described how the midwife cared for them so that they were more confident to care for their babies. Ruth described a time when the midwife leaped in to provide care (Heidegger, 1962/2008). It was this action that contributed to her feeling of being cared for

> *During my birth, she was just amazing. She said this is what’s happening and then she’d check in with the doctors when she needed to. She didn’t stand back and let me go because I was at the hospital. She took charge which I appreciated, and I felt really cared for. My mum and sister turned up when I was in labour and my midwife didn’t let them in as it wasn’t in my birth plan. She came and asked me if I would like my mum to come in. I was thinking, it doesn’t matter if mum’s here or not. Mum said the midwife checked on them and would fill her in on what was happening. When my baby was born, my family were excited and came to the door and the midwife said they needed to wait. She was super respectful. I was laughing inside thinking it’s just mum, but I thought good on her for asking. It was the same thing when she came over to my house. I’d say would you like a drink and she’d say, yep, maybe your mum can get that. She was clear that my job is to look after the baby. The visit would be about me and the baby. It wasn’t a chat to my mum and see what she’s been doing (Ruth, woman).*

The midwife advocated for Ruth at a time when she was less able to do so for herself. The midwife talked with the doctors to ensure that Ruth’s wishes were forefront. She checked in with what Ruth wanted. She talked with Ruth’s family so that they knew what was happening. In other words, she smoothed the way for Ruth within the hospital environment and this contributed to her feeling cared for. It seemed that Ruth was aware this midwife had

a choice about how she cared for her once she transferred to the hospital. In this situation the midwife could either stay and provide care, or she could hand over care to the hospital midwives. While any midwifery care would likely have been similar, the hospital midwife would not have been known to Ruth. Knowing the midwife, and perhaps also being known, was important to Ruth at such a vulnerable time. I wonder if being 'let go' by the midwife should she end up at the hospital concerned her during her pregnancy and labour? Would being 'let go' at such a vulnerable time have eroded the trust that had built between them? Ruth was grateful that this midwife who was known remained with her. The midwife's being-with reassured her that this midwife cared about what happened to her.

Ruth's family were excited about this new baby and wanted to support Ruth. The midwife had come to know Ruth during the pregnancy and drew on this understanding to provide care that met her needs. Ruth had not planned for her family to be present during or immediately after the birth and so the midwife stopped them from entering the birth space. She checked with Ruth and they made a plan to support the family's desire to be involved. The midwife kept the family updated, yet at the same time she protected Ruth's space. It takes tact and sensitivity for the midwife to manage such relationships at a time of high emotion. This midwife was inclusive of the family, even as she made it clear that the woman's role was to care for her baby, and for the family to care for Ruth. In being considerate of the needs of Ruth's family, it seems this midwife contributed to Ruth feeling cared for. She could focus on her own needs because the midwife had supported the woman and her family to adjust to the arrival of the baby. Caring for the woman comprises being inclusive of her family and friends who support her, while prioritising the needs of the woman.

A trusting relationship enables the woman to grow

During pregnancy women learn about themselves, physically, emotionally, and perhaps spiritually. It may be that the woman is more open to developing a deeper understanding of herself when she has a strong bond with a midwife whom she trusts. Milly described the impact of her relationship with the midwife for her second birth.

> *I never knew my relationship with my midwife could have such a powerful impact on my journey as a mother and a woman. She stepped back and enabled me to totally trust my body and myself. Her calmness, confidence and knowledge gave me the confidence to be in control and trust myself. As a result, my birth made me feel powerful and exhilarated. We learnt so much about birth, midwifery, and ourselves because of our discussions with her and*

> *the knowledge she shared. She took time to get to know us, and we felt she genuinely cared about us and always knew the best way to support us. Her attention and care during the first few weeks of my son's life helped me grow my confidence as a mother (Milly, woman).*

Milly trusted her ability to birth in part because of the midwife's trust in her. The midwife's way of being-with her opened the way for her to learn about herself. In leaping ahead, the midwife shared her knowledge. They talked together about birth, about midwifery and shared information about themselves. They journeyed together to care for Milly and her baby. This relationship was different to the relationship she had experienced with her first midwife. Perhaps there was greater reciprocity, perhaps both were open to the relationship that connected them. Gadamer (2013) describes such relationships as I-Thou. Such relationships are special and are more than a knowledge of human nature. Rather this includes being open to each other as someone who is unique. Gadamer (2013) suggests that "without such openness to one another there is no genuine human bond" (p. 369). Because of this relationship Milly felt more confident in her ability to birth and to mother. She had come to know more about herself and what she was capable of. This knowing helped her to feel powerful and in control of whatever might be ahead. However, this self-growth is not something the midwife can do alone, since the woman must be open to such possibilities.

Being trustworthy

We are more likely to trust if the person to be trusted shows themselves to be trustworthy (Hardin, 2002). Trustworthiness is described as being "dependable, capable, responsive and responsible" (Flores & Solomon, 1998, p. 209). An individual's trustworthiness can be assessed by knowing them or by their reputation (Hardin, 2002). It is suggested that when the person to be trusted values the continuation of the relationship, then it is in their interests to consider the interests of the other (Hardin, 2002). In this study when the midwife was responsive to the woman, and showed that she cared, she was regarded as trustworthy. This section considers the ways that midwives and women experienced being trustworthy.

A woman trusts the midwife is keeping her and the baby safe

Meeting regularly during the pregnancy gave time for conversations about what may happen in the journey ahead. These conversations gave the midwife an understanding of what was important to that woman. Birth is a time when the woman needs to trust those who are

caring for her so that she can focus on birthing. When the midwife is known, the woman may sense her mood in response to how the birth is unfolding.

> *The thing I loved about her was she did steps I didn't realise she was doing for a purpose and without making a big fuss of things. When the baby was born, the cord was around her neck and she calmly said to my mum, 'do you mind pushing that orange button'. All the midwives came rushing in and she said the baby's just a bit stunned. I thought I can't hear the baby cry, but I know it will. I wasn't anxious. I felt safe. I had this trust that things were going to go okay. I thought, this probably happens a lot because of her calm, collective manner. I trusted that she knew what my wishes were. She asked questions I never expected. It was important to talk about things that can be controlled! My midwife watched me for 9 months and saw me and my baby grow, and provided care at a very, very vulnerable time. I think she cared about me and she cared about my baby (Stella, woman).*

Stella was able to pick up on the midwife's response to the unfolding situation. The midwife's calm approach reassured Stella that she and her baby were safe. If the midwife was not concerned, then she should not be either. After all their time together, she trusted the midwife would do what was 'right' for her. It is likely that beneath her calm exterior the midwife had switched into emergency response mode. Neonatal resuscitation is something that midwives prepare for and she would have had experience in responding to such circumstances. A 'stunned baby' did not sound life threatening. I wonder how this relationship would have fared had the baby not responded to the midwife's care. Would the relationship they had developed sustain them through the difficult conversations that would have lain ahead? Over the nine months of pregnancy the midwife had asked many questions, including about things Stella had not even considered. Of course, they could not talk about everything that might occur. But talking about many things gave Stella confidence that the midwife could be relied upon to keep her and her baby safe.

Everything the midwife did reassured Stella that she was trustworthy. She had asked lots of questions and she understood what was important to Stella. She was responsive to Stella's needs and did not make a fuss about the care she gave. She showed herself to be capable and just got on with it when the need arose. Having a trusted midwife provided Stella with the confidence to be herself and get on with what she needed to do to birth her baby. It is important that the woman can focus on what she needs to do within the birth process and not be distracted by those around her (Lungren, 2018). Their relationship was such that Stella was confident the midwife knew what her wishes were without needing to make these explicit. However, failure to check 'this' woman's wishes carries the risk of upsetting the trust that was evident in their relationship. More likely, the midwife could read Stella's response to

know the ‘right’ thing to do, and so she continued to provide care that met Stella’s needs. Her attention to Stella’s needs left her feeling cared for and safe.

A midwife’s respect for a woman builds trust

Not all women come to the relationship ready to trust the midwife. It may take time, or a particular moment for the woman to determine that the midwife is someone she is ready to trust. Even then, it may be that the woman can only engage in the relationship on her own terms. This midwife’s attunement with the woman opened the way to a relationship.

> *The woman was a non-attender and we visited her at home a lot. She gave up smoking and was responsible for stopping her whole whanau from smoking in the house. It was midnight when I came to her in labour. The whanau had gone out to the garage for a smoke. She said, ‘I made them do that and I feel stink’. I said, ‘oh you’re a hero for that’! She gave me this huge smile and I have always wondered if that was when we connected. I didn’t know her well at that time because we’d hardly seen her. She’s difficult and problematic but somehow, she’s got a bond with me that surprises me. I respect her ability to look after her children in her pregnancies according to what she knows is right (Rose, midwife).*

How do midwives manage a relationship with a woman who is not seeking one? This woman was standoffish in the relationship. She regularly missed her appointments. It may be that this woman just wanted someone to do the basics. Perhaps she saw the midwife as interfering in a life that had already been interfered with and over which she may have felt she had little control. For this woman, it was a huge leap to trust someone else. When she shared her concern, the midwife’s response opened the way for their relationship to develop further. Sartre (1992) suggests “I see myself because somebody sees me” (p. 349). Perhaps it was the respect this midwife showed for this woman’s efforts to keep her house smoke free that opened the way. Despite the relationship remaining on the woman’s terms, Rose enjoyed a connection with her that she had not expected to. Maybe a connection of sorts is good enough.

Women who protect their space can be seen as distant and maybe even aggressive at times as they rebuff the midwife’s approaches. It may be that this woman had no experience of trusting. Flores and Solomon (1998) suggest that “one learns to trust by trusting and that is how one gets good at trusting which includes the knowledge of when not to trust” (p. 212). To know how and when to trust requires practice. While it seems this woman came to trust Rose, she continued to maintain a distance within the relationship. Nevertheless, Rose regarded their relationship as positive, despite the challenges she experienced. Perhaps

seeing the woman open up, even just a little, sustained Rose in her efforts to care for this woman. Despite her remaining difficult and problematic the midwife enjoyed seeing the woman doing the best that she could and respected her because of this. It seems that a positive relationship sustains the midwife through challenging care situations.

Feeling trusted by the woman's family

The midwife has a contractual agreement to care for the woman. However, the woman is part of a family who are also involved in her pregnancy journey. The midwife will often meet family members if they attend her antenatal appointments. It is likely that the woman's wider family have an influence in how the woman engages with the midwife. The midwife comes into each new client relationship not knowing whether the woman will readily trust or whether this will only be gained after a period of time. Nor does she know the understandings the family hold about birth. Gaining the trust of the family can be part of gaining the trust of the woman.

> *There was a mum who was protective of her daughter. We had long appointment times and we did this negotiation all the way through. When the girl went into labour, it wasn't easy. There was an emergency and a few things I had to do. The mum took my hand halfway through and said, 'you've spent 9 months building a relationship with us and now I see you doing your job. I'm just going to let you do it'. I thought she would be trouble when it all fell to pieces, but she just stood back and let me do it. She was an amazingly fierce lady, but I got on with her (Deb, midwife).*

It takes time and interpersonal skills to build a trusting relationship. Providing care during the pregnancy allowed the woman and her mother to come to know this midwife. Their discussions gave Deb an insight into how this birth might playout. It seemed that everything she did was up for negotiation. Nothing was straight forward. So much so that Deb feared the mother could be difficult to work with during the birth. Perhaps she would want to negotiate when there may be little time to do so. It was during the birth that Deb most needed the woman and her mother to trust her to do what she needed to do to ensure a safe birth. Deb made time for long appointments to work through their concerns. It may have been her willingness to talk and negotiate that allowed the mother to trust her. Perhaps it was the information she shared. Or it could be the relationship they established that reassured the mother that this midwife was trustworthy. Either way, this midwife was attuned to how she might build the relationship effectively for the woman and her mother. Her knowing of the woman and her mother, and her way of being-with, paved the way for a trusting relationship.

Trusting requires giving up control to the person who is trusted (Flores & Solomon, 1998). Perhaps it was only seeing the midwife's care for her daughter while in labour that the mother was ready to trust this midwife. Perhaps at that moment the mother had little choice. Her daughter needed support and this midwife had shown herself to be capable. Events during the birth drew on the midwife's skills and may have required her to seek additional help. Maybe the mother felt helpless at such a time and worried whether her daughter was safe. Their conversations during the pregnancy provided a foundation for the mother to trust this midwife. It may be that the trust they had developed helped them through the uncertainty that the 'emergency' created. Yet trust is always under negotiation. What would have happened to their relationship had this midwife's action left them feeling let down? Midwives tend to the relationship throughout their time together to ensure that trust is always being maintained.

Trust is a thin line

It may be hard for the woman to fully trust again when her birth did not go as she expected. Perhaps what was unexpected was only one episode amidst many others of the midwife being trustworthy. Perhaps in knowing of the concern, the midwife has the ability to show she should be trusted. This woman returned to the same midwife for her second baby despite not quite trusting her.

> *The woman had a fast labour and a lovely birth first time, but she screamed with the pain of the birth. The first two and a half weeks were a fog for her. She said, 'I can't go through that pain again, you have to give me a C-section this time'. We talked about possible complications and I suggested an epidural. She agreed but every visit she asked if I was going to give her an epidural. She still had this mistrust in me and the system. I was a bit worried. She came in in strong advanced labour. I said just put the epidural in and everybody said this is crazy. How can you give a woman, who's already had a vaginal birth without an epidural, an epidural? We put the epidural in and as soon as it was working, I examined her. She was 9 centimetres, so I broke her waters and she had her baby. She obviously had post-traumatic stress disorder after her first birth and the way she was going to get through it was with an epidural. And I did that for her. Our relationship bloomed from then on. I gave her what she wanted, and what she wanted worked. I think the trust she had in me was a very thin line (Carol, midwife).*

The woman was prepared to trust but only on her terms. This midwife had been given another chance and so did not want to let her down another time. Of course, Carol could not have foreseen the woman's reaction to her first birth experience. Carol remembered the woman's birth as lovely, but unfortunately this was not the woman's experience. Carol took time to understand the woman's concerns and make a plan that would work for her. At each

visit Carol reassured the woman that she would keep her safe and care for her as they had agreed. Her attunement with the woman's understanding of her birth experience led her to advocate on the woman's behalf at a time when the midwife's colleagues did not agree with her plan. Being-with the woman meant that Carol was working in a way that was not her usual practice, nor that of her colleagues. Yet it was a plan that addressed the woman's concerns. Such care suggest that holistic practice contributes to trust.

There were no guarantees that the plan would work out. The anaesthetist may not have been available, or the woman may have progressed too quickly. Either way, the midwife took a gamble. So too did the woman. Perhaps she wondered if the midwife would try and tell her there was not enough time for an epidural. I wonder how their relationship may have fared had the plan not worked out. Any breach of trust at that time would likely impact their ongoing relationship. A breach of trust can leave the woman feeling bereft, with her reaction out of proportion to the breach, since it is the loss of trust that is significant. However, it may be that the midwife had leaped ahead drawing on her accrued knowledge of this woman. It is likely that both knew the uncertainty of how the birth might play out. In making a plan together the midwife had done all she could to give the woman some control of her birth. How it played out would remain to be seen. When it did work out the woman's trust in the midwife was upheld. Had it not worked out the woman may have accepted the midwife did all that she could to meet her wishes. Perhaps even trying her best would be enough. However, trust that is tested and lost may be difficult to regain.

The midwife learns to trust the woman's trust in her own body

Midwifery in New Zealand is bound by regulatory and professional frameworks with informed choice and consent underpinning midwifery practice. However, there are times when supporting a woman's choice can be challenging to the midwife and requires a high level of trust in the woman. Judy discussed a time when she was pushed to trust the woman's trust in herself.

> *I cared for a woman with all of her babies. Her first one was a stillbirth, so with her second baby, I referred her to the consultant. She was a bit hesitant about going. Afterwards she said "I know what the risks are. I'm not going back there and I'm not going to be induced at 38 weeks". She spontaneously laboured and had her baby at the birth centre, and it was amazing. She pushed my boundaries, but I have immense respect for her. With her third baby she didn't want any contact with an obstetrician. She went overdue which did my head in. My partner and I had many conversations and I always had to keep coming back to, she's healthy and she*

doesn't have risk factors. I got her to sign stuff in her notes. She knew that my boundaries were pushed but she knew what the benefits were. She had lost a baby, but she trusted her body like no one I've ever cared for (Judy, midwife).

Being-with the woman can challenge the midwife. The College of Midwives' philosophy underpins midwifery practice in New Zealand where the woman is empowered to explore her autonomy (Pairman & Guilliland, 2010a). In doing so this woman made a decision that went against the medical advice she received. This left Judy in a quandary. Judy considered those things that made the woman's decision reasonable. She discussed the situation with her practice partner. As she came to understand the woman's hopes and fears, it may be that her horizons of understanding were altered. Trusting the woman meant that Judy needed to give up some control. This was not a comfortable space for her. To keep herself safe she documented their decision making and asked the woman to formalise her understanding and agreement by signing her notes. Being-with the woman may require the midwife to review her practice and to make decisions that go against her usual practice. Yet the depth of their relationship sustained this midwife through these difficult decisions. Informed choice and consent enabled trust which in turn, supported the midwife's being-with.

This midwife wanted to support the woman in her decision, but she was aware of the 'they'. Heidegger describes how "Dasein does not see the world with its own eyes but sees it in the way that others do" (Harman, 2007, p. 177). This midwife found herself occupying the space between the woman's decision and medical ways of working. 'They' wanted this baby induced to mitigate the perceived risk for this pregnancy. 'They' saw intervention as a way of keeping this baby safe, whereas the woman saw waiting as the way forward. Midwives work in these spaces and look for ways to bridge the gap to support the woman's autonomy while ensuring that she and her baby are safe. Since neither know for sure how things will play out, situations such as these require a high trust relationship. Stepping outside of accepted ways of working carries a risk for the midwife. She needs to know whether the woman understands the decision she is making. She may wonder if the woman will hold responsibility for her decision if it does not work out. She keeps wondering if her own practice will stand up to scrutiny. It seems the woman and this midwife talked about the possibilities that lay ahead. They shared their fears and respected each other's position. Their attunement is evident as both worked through this woman's journey. The positive outcome validated the woman's stance and left this midwife in awe of the woman's confidence in her own body. I wonder, had the outcome been different if their relationship would have sustained them through the experience. How does trust fare if a baby dies, or

even the woman herself? Hindsight can expose bold decisions based on trust to intense scrutiny.

Trust remains, even after a stillbirth

An adverse outcome may challenge a trusting relationship. How those involved respond, or whether any perceived omission in care is attributed to the midwife, will influence the trust remaining in any ongoing relationship. The midwife may be uncertain whether the woman continues to trust her, and this can make their relationship feel awkward.

> *I'll never forget after that baby was born, she said to me, oh you're upset too. I was a bit tearful and I remember her husband saying, oh you're a real person. And I just thought, yeah, I am a real person. Sometimes women and families see a health professional as someone who doesn't have emotions. She invited me to the consultant's appointment after the birth with her and her husband. I was really grateful she came back to me for this birth. She said this will be a healing journey for both of us (Annie, midwife).*

This relationship was tested by the events of the birth. This left the midwife alert for cues from the woman as to whether her presence and care were still welcome. Perhaps she wondered whether the woman harboured concerns about her practice. Such concerns can undermine trust. Maybe the relationship they had built during the pregnancy provided evidence of this midwife's sincerity and her commitment and competence in her role. Her response to their loss had shown the woman and her husband that she did care. It seems the woman and her husband had not expected her to be moved by their loss. Perhaps they expected her to be 'professional' and distant. Her response showed that she shared their experience and that what was important for them was important for her also.

The woman's invitation to meet with the consultant, and then to care for her again opened the way forward. Annie was grateful to have opportunity to care for the family again with the expectation that it would be a positive outcome. Maybe as each recognised that the memory of last time went ahead of them to be there in this new pregnancy (Heidegger, 1962/2008), there was an unspoken understanding of the quiet dread that was still there. Even though their baby was still born, it seems this family had not lost their trust in Annie. Moreover, it is likely they realised she would be as vigilant as she could possibility be to avoid a second stillbirth. Flores and Solomon (1998) suggest that "trust, like love and indignation, finds its significance in the bonds it creates" (p. 213). The essence of trust endured due to the relationship. Yet trust may be "cut short, betrayed, interrupted … because it has been

foolish” (Flores & Solomon, 1998, p. 213). Even though a stillbirth is a terrible outcome, there is no sense that this family felt it had been foolish to trust this midwife.

A strong bond

The midwife and woman can become very close as they work together through the pregnancy journey. For some women, the relationship was profound and left a lasting impact on them. Jo tried to describe the things that contributed to how she experienced the relationship.

> *My first midwife is possibly one of the most amazing women I’ve ever met. She was incredibly compassionate and understanding right from the word go. The fact that she travelled to my house for our appointments made a massive difference. She explained the process of how it all worked. She was really clear and well documented, so that made me comfortable. For me it was her coming and saying this is how it runs and when we get to this stage, we’ll start looking at these things, and when we get a bit closer, we’ll start looking at these things. My second midwife was fantastic too. I’ve got absolutely no qualms with her. I’d had such a strong bond with my first midwife, you know there was never going to be the same with the second one (Jo, woman).*

Jo felt her first midwife was one of the most amazing women she knew. The midwife took the time to do home visits, she explained how things would work in a way that Jo understood, and she documented carefully. She looked ahead to help Jo be prepared and to limit any surprises. In leaping ahead, the midwife showed her care for Jo by preparing the way for her (Heidegger, 1962/2008). While Jo lists professional behaviours, she also includes relational attributes of compassion and understanding. In her everyday being-with the midwife provided care, yet for Jo, the midwife’s compassion and understanding shone through and was special. It is clear that Jo came to trust the midwife. Such feelings resonate with Carl Rogers (2003) concept of ‘unconditional positive regard’ whereby love and acceptance of the other person as they are, free of judgement, along with empathy and authenticity, supported the client to grow in themselves as a person. Such feelings sound a lot like trust. Hardin (2002) advises that trust is built on expectations that are specific, rather than generalised. This midwife provided care that was specific to Jo at a time when she was vulnerable. Their shared experience created a trusting bond that was enduring. It seems that the experience of the positive relationship sustained Jo through her subsequent relationship. Trust can be generous.

Jo did not expect to experience such a deep connection with her next midwife. That midwife, while "fantastic" did not elicit the same response in her. Yet, it seems that Jo was not disappointed with the next midwife. Rather, she accepted that this was how it was. Perhaps she retained a sense of loyalty toward the first midwife and this coloured her memory of that relationship. It may be that she did not need another deep relationship for this second birth, as the first experience sustained her throughout this subsequent experience. I do not know what expectations the next midwife held for the relationship or whether she was disappointed that they did not connect in the same way. Midwives are attuned to the relationship and it is likely the midwife knew that Jo compared her with the first midwife. However, it seems that Jo trusted this second midwife and their relationship that was 'good enough' was all she needed this time.

Trust in hindsight

The woman's experience of her previous midwife-woman relationship shapes her understanding of how the relationship 'is'. Perhaps it is only in hindsight that the woman may realise how important the relationship was to her birth experience. When Serena's expectations were not met by her next midwife, she searched for the first midwife to ask if she could care for her again.

> *I asked her, "can you be my midwife because I trust you. When you became my midwife the first time, everything fell into place. You spoke to me about everything. It's like you helped me to become a mother when my mother wasn't there". Every little step she took me through, I took it in and that's how I survived being a mother. She gave me lots of information. I feel like I open up more because she actually cares. I breastfed my son until he was 2 years old because of her help. When I came out of hospital, she came with a gift bag with some nappies, wipes, and baby lotion, to help me out. That meant so much to me because I was struggling. When her care ended, I felt grateful to her that I've been through the worst, now I can see the sunshine (Serena, woman)*

This midwife had shown herself to be someone Serena could trust. Everything she did contributed to a positive experience for Serena's first birth. She recognised Serena's need for support and provided it by way of information that was 'right' for Serena. She brought a gift bag containing items that were useful. This midwife showed she could be depended on to support Serena when she needed it. The midwife's care helped to fill the void left by an absent mother, and perhaps in doing so created a mood of possibility, just as her mother would have done. Serena attributed her success as a mother to the care she received from this midwife. I wonder how she might have understood the relationship had her birth or postnatal experience not gone as well. Would the trust have been sustained? It seems that

at the time Serena took the positive relationship for granted, that this was how it was in all midwife-woman relationships. Perhaps it is only in retrospect the woman may appreciate how a positive trusting relationship can influence how she saw her birth experience.

Feeling cared for opens the relationship. The midwife's actions showed Serena that she cared about what happened to her. The midwife did not judge her situation but instead offered practical support. As the midwife showed herself to be someone she could trust, Serena shared more of herself. However, sharing can be tricky. Too much may leave the woman feeling vulnerable. Too little may leave the midwife guessing about what is important for the woman. The onus is on the midwife to manage this balance between knowing the woman while also protecting her from oversharing. It seems that their attunement helped Serena and the midwife manage this tricky passage. Their back and forth of conversation contributed to the development of a shared understanding (Gadamer, 2013). As this midwife got to know Serena, she tailored her care to meet Serena's needs. Perhaps it was in being cared for as herself that everything was able to 'fall into place' for Serena.

When the midwife-woman relationship comes to its closure

Caseloading midwives in New Zealand provide care up to six weeks after birth. The midwife woman relationship is over a specific period of time for the purpose of providing care during the birthing journey. The participants in this study have described how over the course of their time together they came to know each other and gained an understanding about how the other may be trusted. The closure of the relationship was an important milestone for the woman and the midwife. The woman and her baby would move on to receive care from other health professionals. The midwife could leave knowing she had done all she could to support the woman for a positive mothering experience. This section considers how participants managed the closure of the relationship.

Feeling like you have lost a vital person

The midwife had discharged Maisie from her care a couple of days ago. Yet Maisie was feeling her absence already.

> *The midwife is such a vital person in your life, it's huge. We said our goodbyes on Friday, and I feel completely lost without her. It feels like you've lost somebody. I wonder how midwives feel about that. They've got to have a personal attachment and wonder how we are getting on. Maybe it's just a job. It feels like they're there at*

> *your most vulnerable and your most empowering moment and then they're gone, poof (Maisie, woman).*

The midwife was 'there' for this woman throughout her pregnancy journey. She had maintained a nearness that was reassuring to this woman. She had been with Maisie when she felt vulnerable and had also been present when she felt empowered. This midwife had witnessed her transformation into a mother. She was someone who was trusted and now she had gone. Even though the time elapsed since the midwife stopped visiting was less than the gaps between visits, Maisie was missing her already. It seems that Maisie did not feel prepared for the reality of not having the midwife available. She wondered whether the midwife continued to think of her. The relationship had been important to her, but she was not sure how important it had been to the midwife. There is a sense that she felt let down by the departure of the midwife. One moment she was 'there', and the next she was gone. I wonder whether the work they did together to build the woman's confidence lingers on long after the midwife has gone. Perhaps that is the paradox of a relationship that is strong and engaging. It comes to an end with a sense of loss.

The midwife draws back from ongoing friendship

The midwife is engaged in relationships with many women over the course of their birthing journey. While some relationships were special to the midwife, they remained professional relationships for this midwife. Indeed, any continuation of the relationship outside of the purpose of it would require them to review the nature of it. Hence, Judy decided that she did not want to have an ongoing relationship with the women she had cared for.

> *Sometimes I could be friends with some women. But I'm always careful with that and I don't have an ongoing friendship with any woman that I've cared for. I have contact with some groups that I have cared for them all. Someone might ring and say I thought I'd let you know that such and such happened. Or they might ask me for lunch to see them all. I have photos at home of all the kids on the couch. Often women will say, do drop in for a coffee. That is thoughtful, but the reality of life is that I am busy enough without adding visits with ex-clients. I will always stop and talk if I see them, but I am busy doing my own things (Judy, midwife).*

The end of the pregnancy care signalled the end of the relationship in its current state. While Judy enjoyed some of the women she had cared for, she decided not to pursue a social relationship with them. When some of the women kept her updated on what they were doing, she enjoyed hearing their stories. She was happy to engage with them, but this was on her terms. While Judy liked to hear what they were doing, she regarded any ongoing contact as part of her work. Her life was already busy and so this additional work was something extra to add in.

It may be that outside of their shared journey with the woman's birth, that the midwife and the woman have less in common. What do they talk about when their shared topic of interest is no longer paramount? I suggest that any move toward a friendship would require the renegotiation of boundaries and expectations to become a reciprocal relationship. If not, it would likely remain a professional relationship with the focus on the woman. Maintaining a relationship of sorts is in the interests of the midwife as a self-employed practitioner. Ongoing contact of any kind may allow the midwife to hear what she did well, or perhaps any concerns about the wellbeing of the woman and/or her baby. Additionally, her ongoing presence may result in her services being recommended by the woman to other women. Of course, it is likely that she is interested in the woman for herself. Afterall they have spent time together and have come to know each other through a shared experience that binds them in humanity. Seeing the mothers and babies grow up is a rewarding part of the midwife's professional life. Thus, while the nature of the relationship changes, trust likely remains, albeit from further afar.

Seeing each other afterwards

If they remain in the same community it is likely the midwife and the woman will see each other as they go about their lives. For this midwife, seeing the woman and her family within her community was an enjoyable part of her work as a midwife.

> *I see people in the waiting room where I have my clinic and they want to come up and give you a big hug and say hi and this is so and so and look how big they are now. Now I look after people where I've also been the midwife when they were born. I often see that as a bit of a bonus (Annie, midwife).*

There is a sense of being-with the family for this midwife. The families embraced Annie and were proud to show her how much their children had grown and how well they were doing. Perhaps because of the care she had provided them with. It seems she held a special place in the story of those families as the midwife who had been with them, and so they welcomed her presence. They remembered her care of them and sought to maintain a connection with her. I wonder how the woman and midwife would feel meeting by chance when the relationship had not ended well. I suggest that both may feel awkward and avoid each other. When the relationship went well, the woman and midwife enjoyed seeing each other again. It was an opportunity to share the success of the family and for the family to acknowledge the midwife's role in that success. The time they had shared together and the trust they had

created continued over time. Getting together, even after a period of time had elapsed allowed for the relationship to resurface. It seems that trust has a long memory.

Conclusion

It is clear that trust is central to a midwife-woman relationship that 'works'. Trust is grounded in expectations that are specific to the other person in the relationship (Hardin, 2002). The midwives described ways of working to discover what was important to the woman and how she could best care for her. I remember how Heidegger (1976) suggested that the cabinetmaker became skilled when they responded to the different kinds of wood they worked with and recognised the possibilities that lay within each piece of wood. Working with the grain of the wood to uncover what lays within is part of the skill of being a cabinet maker. So too, the skill of the midwife lay in uncovering the possibilities of each woman; whether she was open to the relationship, whether she trusted or could be trusted herself. In doing so the midwife tailored the relationship and her ways of being-with to open the woman to what was possible. Midwives enjoyed working with women who were open to such possibilities.

Trust can never be taken for granted. It is always being renewed and maintained. It seems that even some trust opened the way to a relationship that felt more positive and had greater possibilities. But deep trust opened the way for a relationship that felt profound to both the woman and the midwife. Trusting and in turn being trusted made the work more meaningful for the midwife. A high trust relationship enabled the midwife to support the woman's decision, even when that went against medical advice. It enabled the midwife to leap in to provide care in an emergency, confident that she was meeting the woman's needs because of the understanding they shared. It also gave the woman confidence that the midwife had her back at a time when she was vulnerable. Creating and maintaining trust is paramount when providing midwifery care to keep both safe at a time of uncertainty and vulnerability. Trusting the midwife gave the woman a deep sense of 'feeling safe'. The next chapter will pull together the threads that make up the findings from this research and suggest recommendations for midwifery practice.

Chapter 9: Reflecting on the relationship

Introduction

This study explores how caseloading midwives and the women for whom they care understand the professional relationship. Following the hermeneutic phenomenological approach, midwives and women who had experienced caseloading practice were interviewed about their experience of the professional relationship. These stories were analysed drawing on the work of Heidegger and Gadamer to consider not only what was said, but to also look beyond this to ponder that which was unsaid. I have explored my role as a midwife and researcher who is embedded in the study and described my journey through hermeneutic phenomenology. This chapter discusses the findings described in the previous four chapters and relate these to our understanding of the professional relationship. What was uncovered suggests to me that it is through trusting that the relationship works. I will consider the ways in which these findings contribute to existing research regarding the midwife-woman relationship. I offer recommendations for the midwifery profession in the spirit of continual improvement and reflect on the limitations of this study. Finally, I make suggestions for further research, for this is only one beginning.

Taking a journey

Birth is often a time of immense emotion (Carter & Guittar, 2014). It heralds the arrival of new roles, of a new person, and of new lives to be lived. It draws on what has gone before and signals what the future might hold. The midwife-woman relationship occurs at the junction between this past, present and future. It is always in play, drawing on our understandings of what 'is'. Achieving a 'good birth' remains central to the relationship, however, what happens along the way contributes to how a 'good birth' is understood. Hence, the relationship can be compared to the notion of taking a journey, always on its way, but never quite 'there'. Like any journey it may be straightforward and easy, or it may be filled with twists and turns. There may be wonderful surprises and discoveries as our potentiality is revealed, but there may also be potholes and obstacles, perhaps due to complications of pregnancy, social dynamics, or individual vulnerability. The mood one brings to the journey contributes to how we travel. There is a difference in the experience of traveling alongside someone who is excited and looking forward to what lies ahead, compared with someone who is anxious or withdrawn, since the mood of one impacts the mood of the other (Freeman, 2014). My research follows the stories of the midwife-woman relationship over the pregnancy journey through its many twists and turns.

The past, present and future are all at play in the relationship. The midwife and the woman come with understandings of how the relationship may be, and expectations of what matters. These understandings lend a mood to the relationship. They indicate to the woman if the midwife is 'right'. If the sense of right fit was absent the woman might continue to look for another midwife, or she may trust that a connection could come in time. The woman looked ahead to know the midwife would keep her safe through her journey, that she would guide her along the way and advocate for her if required. In contrast, the midwife was more likely to proceed with the relationship out of a sense of responsibility. The midwife was alert to signs of how the relationship might play out, whether it would be straightforward or challenging. If the woman did not engage in the relationship, or did not seem to trust her, the midwife often found the relationship challenging. Yet if there was some sort of connection there in the relationship, the midwife felt more able to manage the possible challenges she saw ahead. Perhaps because any relationship opened the way to building trust.

It's all about trust

I argue that trust is at the heart of the midwife-woman relationship. Trust is created at the first encounter and maintained, or not, within relationships (Beitat, 2015). It is cultivated through conversations that develop a mutual understanding, and through commitments and actions that reassure the other (Solomon & Flores, 2001). It draws on past experiences of trusting to inform understanding of whether this person can be trusted. Trust supports working together which in turn is linked to better outcomes because it "enables people to bridge gaps left by unknowns and uncertainties" (Beitat, Bentele & Iedema, 2013, p. 72). It is likely that in commencing the relationship we assume trust, until a boundary crossing or breakdown in the relationship announces its loss. However, trust is never gone, in the same way that trust is not established and then forgotten (Solomon & Flores, 2001). Rather, it is a dynamic social practice that is flexible and reasonable, and so is open to possibilities, but only if we work to maintain it (Solomon & Flores, 2001).

Trust is complex. While basic trust may assume nothing untoward will happen, simple trust is not suspicious that anything untoward could happen, whereas blind trust denies the possibility of anything untoward happening (Solomon & Flores, 2001). On the other hand, authentic trust is trust that is "reflected upon, it's risks and vulnerabilities understood, with distrust held in balance" (Flores & Solomon, 1998, p. 213). It is shown in the making and

keeping of promises, by a look, gesture, or touch, in the reassurances given, and by knowing which words to use, and which to avoid. It is characterised as much by “doubt and uncertainty as by confidence and optimism” (Solomon & Flores, 2001, p. 93). This means it foresees the possibility of a breach but also sees what trust remains. Authentic trust is not taken for granted. It develops through conversation and negotiation so that each other’s responsibilities are known. So, if trust underpins the relationship, how does it play out?

Trust is conceived through communication

Trust is conceived through the back and forth of conversation, for this is how the woman and midwife come to ‘know’ each other and negotiate a mutual commitment to their journey. The creation of a shared understanding can only occur if both are willing to engage in conversation and are open to the other’s opinion (Gadamer, 2013). Of course, these conversations may not be easy and can take time. Sometimes it seemed trust was evident quickly, while other times it was more elusive. Such trusting was hard to articulate, yet participants noticed its absence. For the woman, trust waivered when it seemed the midwife did not understand how she felt or did not make her feel known. For the midwife, the struggle to trust came, for example, when a woman seemed to be avoiding her visits or did not respect her advice. Trusting can open the way to a relationship characterised by open communication, self-confidence, and knowledge. This is not to be confused with a relationship where the midwife is familiar with the woman. Rather, this is about having conversations that explore ‘how we will do’ whatever together (Solomon & Flores, 2001).

Reaching an understanding took more than just listening to what was said. Gadamer (2006) suggests that speaking with another person is not speaking past them, or arguing things out, but is talking about things that they have in common. The midwives were curious about the woman as a person, they asked questions and followed up on what was not said. They allowed the woman time to think, and they watched her nonverbal ways of communicating. They reflected on the care they gave and worked to understand the woman’s responses in a way that made sense. They responded appropriately. One such example was Clare (midwife in Chapter 8) who recognised the woman was bothered by something. In recognising the woman’s anxiety, the midwife created the opportunity to build trust by creating a plan with the woman that gave her confidence for the unknown ahead. Then there was Jane (woman in Chapter 8) who described how her midwife knew what was important for her even though she did not remember ever saying exactly what she wanted. It is likely that in the back and forth of conversation, the question and answer that this midwife came to understand what

was important to Jane. Such noticing was important to the midwives and the women. Trust is cultivated through conversations and the making and keeping of promises (Solomon & Flores, 2001).

When the woman and midwife had little time or perhaps inclination to converse, they struggled to fully understand each other. This required the midwife to draw on her experience of what she thought was likely to be important. However, the lack of a shared understanding concerned the midwife since she did not know if she might be missing something, or if she could trust the woman should something untoward occur. Remember Judy (midwife in Chapter 7) who struggled to get to know one woman, and who after trying to get it right, gave up and walked away from the relationship, feeling unsafe and unable to even pretend to care. How does the midwife trust a woman who is not ready to trust her? Solomon and Flores (2001) suggest that believing trust is possible is the first step to building trust. Such a belief may be a leap of faith in some relationships, but there is so much to gain in building trust. Things such as a greater likelihood of normal birth (Hernandez-Martinez et al, 2011), and greater maternal satisfaction (Downe et al, 2016).

On the other hand, there was Kiera (woman in Chapter 7), who after initially feeling close to the midwife lost confidence in her and began to doubt the midwife's decisions, yet could not talk to her about her concerns. Conversation could have opened the way to understanding but it seems that neither could find the right words to express their concerns. Midwives need skills to manage difficult conversations in order to build trust (Halldorsdottir & Karlsdottir, 2011). Skills such as creating a mood that encourages conversation, and finding words that open up possibilities rather than imply mistrust. The consequences of not talking about trust is the continuation of distrust which is linked to feelings of "anxiety, resentment and fear" (Solomon & Flores, 2001, p. 103). Such a mood is not conducive to a positive birth experience for either.

Trust assumes competence

The woman came to the relationship assuming the midwife was competent in her role and knew her limits. However, she also sought evidence that she was right to trust this midwife. She noticed how the midwife cared for her. Things such as whether the midwife was skilled, or whether she was organised. She also noticed how the midwife was as a person, whether she was kind and caring, whether she was sincere. When the midwife shared her

knowledge, when she leaped ahead to ensure the woman felt prepared, when she showed herself to be reliable, trust was likely to flourish. One such example is the story of Jo (woman in Chapter 8) who came to trust her midwife deeply because she took time to know Jo and in turn, provided care that was compassionate and understanding. The midwife's care not only met Jo's needs but also anticipated them and so she felt safe. Such behaviour can be described as professional demeanour (Jones & Sin, 2013).

Sometimes we know that things do not feel good by the absence of what feels 'right'. For the woman, it was the midwife who did not listen, who hurried, or who dismissed her concerns or who did not seem to care. Remember Amy (woman in Chapter 7) who felt her midwife did not recognise what she had been through, and instead dismissed her concerns reassuring her that she would be 'fine', even though Amy could not see herself ever being 'fine'. Or Serena (woman in Chapter 7) who assumed her midwife would be as caring as her first midwife, but instead her business-like approach and lack of conversation worried Serena that this midwife did not really care. Such behaviour undermined trust. For the midwife, it was the woman who phoned too often, or after hours about little things, who was out despite having said she would be home, or who lived with situations that left the midwife feeling unsafe. Such behaviour felt disrespectful toward the other and undermined what trust was present.

Trust involves reciprocity

Trust is created through conversation within a relationship. But this is not a one-way process. In coming to know something about the other person we can recognise if they are trustworthy (Flores & Solomon, 1998). In this study participants described sharing more of themselves as they came to trust the other person. What to share and when, could be tricky. Think back to Milly (woman in Chapter 6) who wanted to know about her midwife's family but only enough to be reassured of the midwife's character. It is unlikely that the midwife gets it right all the time as they navigate each relationship. Knowing what, when and how much to share comes from emotional attunement, which includes sensitivity to the woman and being able to understand what is important to her. Despite the notions of mutuality, both the women and midwife participants in this study expected the focus of the relationship to remain on the woman and what was in her interests.

Flores and Solomon (1998) describe trusting as an activity where we must trust each other. Perhaps it is when the midwife shows that she trusts the woman, that opens the way for the woman to trust the midwife in return. Stories in this study described the building of trust during the pregnancy. But in some difficult relationships, trust was only evident after the birth. Could it be that both have got through the unknown of the birth and perhaps proven themselves? Perhaps the midwife has shown herself to be competent, and the woman has shown herself capable of doing what was important to keep her and her baby safe. It may be that with the unknown of birth over they can now relax and trust each other a little more. On the other hand, where the birth has not gone well the midwife may be shunned by the woman, or they may continue in an uneasy relationship, particularly if they have not discussed the events (Waller, 2018). "By talking through trust, trust can be created, distrust mitigated" (Flores & Solomon, 1998, p. 207). Yet if neither trust the other, feelings of resentment and fear are likely to develop (Solomon & Flores, 2001).

Trust can stretch boundaries

Trust can stretch boundaries. The midwife trusted the woman would act in certain ways, such as calling her when she needed to and respecting her advice. Such ways of behaving reassured the midwife that they shared an understanding, and this meant the relationship was more likely to feel positive to the midwife. When there was a high trust relationship the midwife was more open to stretching her boundaries in response to what was important to the woman, likely because they shared an understanding. Remember the story from Judy (midwife in Chapter 8) who cared for a woman whose first baby had been stillborn, and who did not want obstetric care because she was confident in her ability to birth a healthy baby. Yet this situation required a leap of faith for the midwife that in the event of anything untoward happening, that even in hindsight, the woman would stand by her decision. Such a leap required the midwife to examine her own understandings and perhaps to be open to new ways of thinking in order to trust the woman. It seems their conversations traversed the possibilities and explored their responsibilities. Such stretching required the midwife to face her fears, real and imagined, while she remained aware of the 'they' in the background. I am reminded that authentic trust is aware of the risks and dangers, but continues to trust because of confidence in the self and one's own responsibilities (Solomon & Flores, 2001).

Trust may need to be earned

While the midwife's relationship and focus of care is with the woman, this study found times when the midwife needed to earn the trust of the woman's family. Remember Deb (midwife

in Chapter 8) who scheduled long appointments to 'negotiate everything' with the mother of the woman she was caring for. Yet the time spent talking, discussing the possibilities that lay ahead, meant that when it really mattered, when events were unravelling fast during the birth, they trusted this midwife to do what she needed to do to keep the woman and her baby safe. Being trusted allowed this midwife to leap in and provide care at a time when it was difficult to engage in conversation, at a time when a shared understanding prepared the way. It is likely that care with an unknown midwife would have been 'safe'. But it may not have felt safe to this woman or her mother because they would not know the midwife as a person or what to expect from her. Regardless, it is likely the mother watched this midwife closely to ensure that her trust was well placed, and that this midwife would keep her daughter and grandbaby safe. While being trusted made it easier for the midwife at this time, since decision making was given over to her, it also carried responsibility (Flores & Solomon, 1998). If the trust given over to the midwife was abused or neglected, the sense of betrayal for the woman and her mother may have been greater than the breach, particularly if there has been little or no explanation (Beitat, Bentele & Iedema, 2013).

While the midwife can show she is trustworthy, trust must be given by the woman. If a woman does not have experience of trusting she may be hesitant to trust the midwife. It may be she will trust the midwife for something specific, for example, to keep her safe through her birth, rather than in general (Cook, Hardin & Levi, 2005). Midwives in this study worked with women where trust was low and accepted they could still provide care. Such relationships can leave midwives feeling vulnerable and anxious as they work to provide care that is safe while negotiating to ensure the woman remains engaged with them (Thompson, 2013). The support of a trusted colleague made such relationships somewhat easier. Nevertheless, they remained relationships to be avoided in future.

Trust shows the 'right' midwife

Finding the 'right' midwife was key to a 'good' birth. When they met the midwife, the women drew on how they felt as to whether she was the 'right' one. If they felt she was warm and friendly and if she showed that she would care for them and guide them, then she was likely to be 'right'. Finding the 'right' midwife brought reassurance and some certainty at a time when everything was so unknown. It intrigued me that so many midwives were the 'right fit' from the woman's perspective. I wonder if the midwife who is responsive to the woman becomes likeable, and in demonstrating attributes that suggest she is trustworthy, becomes

'right'. This reflects research from England that found that women seek to be supported, and to have appropriate information to enable choices and a sense of control (Borrelli, 2014).

Despite knowing that the relationship was not right, participants shared that it was difficult to put these feelings into words. It seems that where trust opens the way to share, trust that is in flux makes sharing thoughts and feelings even harder (Solomon & Flores, 2001). Perhaps also, in the struggle to articulate the tensions they are feeling there is less tolerance for a careless word that is perceived as 'wrong'. I argue that a low trust relationship has greater consequences for the woman, for it is the woman who needs to feel safe, and it is the woman who may be left with regret from a birth experience that undermined her sense of self because of the relationship. Yet if the outcome was 'good', it seems the women accepted times of the relationship not being 'right', perhaps because in hindsight she was safe.

Trust may be difficult

The midwife participants described some relationships that were challenging. Women who avoided them, who did not follow their advice, or who perhaps had little experience of trusting relationships. Truthfulness is part of trusting and so dishonesty is always a breach of trust (Solomon & Flores, 2001). Remember Annie (midwife in chapter 7) who grew increasingly frustrated by the woman who said she could not come to clinic but was out when she said she would be home. And Clare (midwife in chapter 7) who did not believe the things the woman was telling her because she could see so much more was happening. Each time the woman is less than truthful she risks undermining the trust the midwife has in her. Midwives rely on the woman to call them when they are needed, perhaps not too soon, but definitely not too late, and to tell them about things in their life that may impact on them and their baby's wellbeing. In relationships characterised by poor communication and low trust too much is unsaid and too much is unknown for the midwife to be confident she can provide care that matters, or perhaps that is even safe. Midwives know that if the birth goes 'wrong', or the woman is unhappy with her care, she may lay a complaint. For the midwife, a complaint may result in an investigation by Midwifery Council, with the possibility of losing her practising certificate and therefore her income, or perhaps media exposure and reputational damage. With so much to lose it is little wonder the midwife is vigilant. Yet an investigation into their practice occurred for about 1% of midwives in 2019 (Midwifery Council, 2019). While the frequency of a complaint may be low, the consequences appear to be far reaching.

Although trust may be established quickly in the first meeting, this is likely to be tentative (Flores & Solomon, 1998). A finding in this study was that once the decision was made to engage with the midwife, changing midwife was not easy. Even if the midwife subsequently showed herself to be not quite right, the women were more likely to stay with her for that pregnancy journey. Remember Serena (woman in Chapter 7) who kept hoping the relationship would come right because she trusted the midwife was professional and would care for her. However, the broken promises during her pregnancy meant that the stillbirth of her baby came to feel like the ultimate betrayal. While the risk was always there, the absence of feeling cared for by the midwife made the loss even worse. She had trusted the midwife as a professional to keep her safe and she had not, neither physically nor emotionally.

Then there was Amy (woman in Chapter 7), whose midwife was 'nice' but who she felt was not always there for her, and who did not seem to understand what she had been through. When I interviewed Amy, she discussed finding another midwife for her next birth, someone who could look after her in a way that her first midwife had not done. The following year I received an email from her advising she was pregnant again and requesting contact information regarding counselling for herself. Imagine my surprise when she told me she had returned to her first midwife for this next pregnancy. I wondered whether she had trusted too readily in her first pregnancy and now returned to the midwife with her eyes wide open. Or perhaps she felt that the midwife knew her and that this was better than the unknown. Such a finding challenges the assumption that women who return to midwives for care in subsequent pregnancies were happy with their previous care.

Trust in challenging situations

If the woman was not open and did not share what was important to her, the midwife had to draw on her practice experience to 'guess' what was important to the woman. This did not always work well. Judy (midwife in Chapter 7) struggled with a woman from a different culture. She worked to gain an understanding and to earn the woman's respect to support a relationship that had not been working. Likewise, Kelly (midwife in Chapter 7) who struggled to connect with a woman who then missed two appointments. However, when she tried a different approach the woman engaged with her. The ability to attune with the woman is a skill which enables the midwife to connect with the woman in a way that resonates with her

to support a relationship. I argue that feeling cared for requires more than clinical care, for it was the relationship that made care meaningful and trust possible. Yet for the relationship to 'work' the midwife must be adaptable in order to be with the woman. This may include recognising that the woman trusts the midwife's professional expertise and expects her to make decisions that are in the woman's best interests (Beitat, Bentele & Iedema, 2013). This makes the midwife something of a chameleon as she adapts to the relationship she finds herself in. Within the midwife-woman partnership the midwife trusts the woman to care for herself and her baby. The skill of the midwife rests in recognising the woman's ability to do so and supporting her where required. This is only possible when the woman is known.

Midwives in Aotearoa New Zealand care for women from all areas of society. Government policies seek to ensure equitable health care for women who are disadvantaged. Griffith (2019) highlighted how the maternity system was not working for women living in areas of high socioeconomic deprivation, and that staying connected was often dependent on how much the midwife put into keeping the relationship going. La Veist et al. (2009) argue that mistrust of the health service (or provider) may contribute to delays in seeking care, which in turn can lead to worse outcomes. This supports the notion that a relationship that 'works' is important for the woman's wellbeing through her pregnancy journey, and perhaps beyond. While the midwife cannot eliminate poverty, family violence or mental illness, imagine if all women on their childbearing journey could experience the transformational nature of a trusting relationship. Perhaps this is why the midwives in this study reported working hard to maintain a relationship.

Trust and boundaries

In chapter six I explored how midwives set boundaries and how these were communicated and understood by the women. It seems that boundary work is dynamic in response to how the relationship develops, whether it is trusting and respectful, or not. Over time boundaries were redefined with some becoming tighter in response to transgressions, while others became more flexible as trust grew. When the midwife and woman shared an understanding of how the relationship worked, the relationship was likely to be stronger because they trusted each other to be 'there' if needed. Midwives who were new to caseloading or had a small caseload were inclined to have more flexible boundaries. This allowed them to develop close and responsive relationships to the women they cared for. However, if their workload increased, they struggled to continue to provide care in the same way and instead could find the women's needs overwhelming. Think back to Clare (midwife in chapter 6) who as a new

graduate struggled setting boundaries that were safe for her while also ensuring she was available for the woman. This is a conundrum that many midwives experience. I suggest that as a profession some midwives have confused professional boundaries with relationality and availability. The consequences for women may be mixed messages about the midwife's role (Foster & Lasser, 2011), while for the midwife, it may result in a loss of the joy she once had for her work (Young, 2011).

To provide bespoke midwifery care the midwives drew on professional understandings as well as their own sense of what was right in that moment. There were moments when they shared parts of themselves to create rapport. Remember Rose (midwife in Chapter 6) who shared her own breastfeeding challenges with a woman facing difficulties with breastfeeding. The midwives described being careful not to share indiscriminately. Rather they shared information that they believed was pertinent to the situation in front of them as judged appropriate by them. This flexibility supported the relationship to become closer. However, such closeness can be tricky since what is 'right' is determined by those in the relationship. What happens if the midwife overshares from her own life? Or engages in banter that makes the woman uncomfortable? It can be a fine line to ensure that the focus of care remains on what is of direct benefit to the woman and her baby. However, concepts of professionalism can also hinder the relationship if midwives are drawn toward rigid ways of being with the woman. Getting it right can be tricky and requires the midwife to be skilled in navigating close professional relationships.

Being available 24/7 is not straightforward. Midwives learn how to live their lives while remaining on call. The use of technology such as cell phones gives the midwife freedom to move about while remaining readily accessible to the woman. However, repeated abuse of the midwife's availability was likely to erode trust. Finding the balance was trial and error for some women, and midwives reported being generous in supporting the women to understand their expectations. The risk of making plans is that they are interrupted or cancelled by a call out. Yet not making any plans risks losing contact with living a life beyond work. Think back to Heather (midwife in chapter 6) who put her life on hold in case a woman called her. The nature of midwifery work means that when the woman calls the midwife will probably be doing 'something else'. She may be with another woman, perhaps in labour, or engaged in a family activity, or she could be sleeping. Such concerns caused some women to hesitate to call unless they really needed the midwife. On the other hand, some women seemed unaware that the midwife had any commitments outside of themselves. Such a

diversity in response meant the cell phone might not represent freedom but instead could become an unwelcome intrusion on the midwife's life. While some midwives remain on call 24/7, most work in practices with arrangements for regular time off where their partner will care for their caseload. Such arrangements make working on call more sustainable.

Renewing the conversation with previous studies

It seems that the New Zealand philosophy of partnership upheld by the College of Midwives underpins the midwife's understanding of how the relationship plays out (Guilliland & Pairman, 2010a). However, when the woman did not take on the expected role, perhaps she was reluctant to be engaged in decision making, and did not connect in a person to person way, the relationship was less satisfying to the midwife. There was little opportunity for the midwife to work in a manner that reflected 'partnership'. I suggest the concept of partnership works well with most women, but not all women. This may leave the midwife with the responsibility for decision making with little input from the woman. Or it may mean that the woman makes unsafe choices for which the midwife is left feeling responsible. Such ways of working challenge partnership as articulated by Guilliland and Pairman (2010a). However, within their everyday practice the midwives in this study talked of how they worked to ensure the woman understood what was happening and sought to engage her in the relationship so they could build trust. Such relationships could be hard work. On the other side of the relationship, women shared stories where the midwife did not engage in a partnership and they were left feeling frustrated by the relationship, and perhaps disappointed in their birth experience. They felt they had little opportunity to discuss what was happening and make plans together. For them, their midwife felt like someone who did things to them rather than worked with them in partnership. I am reminded of Simkin's (1991) study which suggests that women remember their births, and it can have a powerful long term impact on them, either positively or negatively.

My findings shed light on the challenges of working within the partnership model upheld by the College of Midwives. Stories from my study revealed the midwife may be left carrying a heavy weight of responsibility, and perhaps feeling resentful toward the woman. But it is the woman and her baby who carry the heaviest burden. They often struggle to access care at a time they are vulnerable. If they do not 'warm' to their midwife they can be left feeling like she is going through the motions of care without 'caring'. Trusting each other lies at the heart of partnership. This study has shown the complex nature of winning and sustaining trust. Achieving partnership can never be assumed or taken for granted.

A study with young Māori women identified they struggled to understand the maternity system and this included finding a midwife (Makowharemahihi et al, 2014). Graham and Masters-Awatere's (2020) study into Māori experiences of receiving public health care found that Māori experienced "coldness, micro-aggressions, discriminatory behaviour and shaming" and that this led them to avoid health care services (p. 7). Other studies in Aotearoa New Zealand have found that women who live in low socioeconomic communities struggled to access maternity services (Griffith, 2019; Priday, 2018). It seems that choice has become a barrier to care for some women. Although my study did not include Māori or immigrant women telling of their experiences with their midwife, from the research mentioned above it would seem that building trust becomes even more challenging.

Continuity of care opens the way to a relationship that can be inherently close as the midwife and woman come to know each other (Fyre, 2013). The women in this study expected the midwife would care for them as a person, providing care that was competent while remaining mindful of their feelings and concerns. The midwives brought an awareness of the responsibility they carried to keep the woman and her baby safe. They also brought experience from the many relationships they had formed and pregnancy journeys they had supported. This contributed to how they regarded being professional. The women in this study recognised that while there was a closeness in their relationship, it was different to the closeness of a friendship. They described the midwife as the lead in the relationship, and they trusted her to keep them safe, both physically and emotionally. Part of keeping safe was understanding how the relationship worked.

It is argued that continuity of care is sought after by women because they prefer personalised care in a trusting relationship (Perriman, Davis & Ferguson, 2018). Within Aotearoa New Zealand, continuity of care is available for all women. This study has revealed the skills midwives bring to build a trusting relationship that supports them to provide care, including for women who do not seem to seek a close relationship. They described behaviours such as taking time to listen carefully to what was said, but also reading between the lines to pick up on what was not said, as well as clinical competence and caring about the woman. Such behaviours have also been described in research undertaken in other countries who do not experience continuity of care (Berg et al, 1996; McCrea & Crute, 1991). As well, midwives in this study reported wanting the woman to respect their advice and preferred to care for women who wished to engage in the relationship. This reflected the

research by Sharpe (2004) into the experiences of women and midwives in Canada. Like the research by McCrea and Crute (1991), the midwives in this study sought to be valued and to have their expertise respected by the women they cared for. Such relationships were likely to feel positive.

This study found that women looked for particular attributes in the midwife, things such as feeling listened to and understood, being sincere and acting in ways that contributed to the woman feeling safe. This echoes other studies which reported similar attributes that helped women to feel confident (Bradfield et al, 2019; Howarth et al, 2011; Lundgren & Berg, 2007; Pairman, 1998; Sharpe, 2004). The first meeting was shown to be important to the women in this study. This enabled them to sense if the midwife felt 'right'. This is reflected in a study by Lewis (2015) where women reported that first impressions of the midwife were important. In both this study and other studies, the women assumed competence from the midwife, but they also described looking for evidence that the midwife was skilled (Lewis, 2015; Sharpe, 2004).

I was intrigued by the similarity in which the study participants described their experiences using the same notions as that of participants from other research who did not receive continuity of care. Qualities such as respect, trust, and caring. As my understanding of the concept of trust has deepened I wondered whether we are talking about trust in the same way. Solomon and Flores (2001) argue that we should not confuse trust with familiarity. Familiarity may provide reassurance that this person may be trusted. There is a risk that this could be confused with assumptions about their competence or sincerity, or for the midwife, that she understands what is important to the woman. When the woman meets the midwife for the first time when she is in labour, I suggest there is a semblance of knowing. The woman has no choice but to trust the midwife, even though this midwife does not know her or what is important to her. The midwife will draw on her experience and interpersonal skills to provide care that seeks to be sensitive and responsive. Midwives who work in such settings are likely aware of the woman's vulnerability at this time. Berg et al, (1996) found that such midwives are skilled in making connections quickly. Likewise, when the woman receives care from a team of up to six midwives, I wonder how can she know them and they know her in any depth (Bradfield et al, 2019; Walsh, 1999). Yet their findings on how the woman and midwife valued the relationship are similar to this study.

What does this mean? Van Manen (1997) describes how other's work may contribute to a conversation that may "suggest different ways of looking at a phenomenon, or reveal dimensions of meaning which we had hitherto not considered" (p. 76). I suggest that women seek a trusting relationship in whatever way this can be achieved, whether this is from a midwife first met when she is in labour, from a group of midwives or a specific midwife where a relationship develops through her pregnancy journey. However, in coming to know the midwife, the woman can be reassured that she is right to trust allowing for a strong bond to develop. Of course, there is also the possibility that the woman does not come to trust the midwife. It is suggested that we live in a society that does not trust readily (Candlin & Crichton, 2013). Relationships with low trust require the midwife to work harder to gain the woman's confidence in order to earn her trust. This study shows how midwives adapt their approach to fit with the woman, as was found in research by Hunter (2006). It is arguably easier to trust an individual who is known over an institution (Flores & Solomon, 1998), for it is in knowing them that we come to understand if they are trustworthy, and we can understand what ways we will trust them. However, Murray and McCrone (2014) suggest that those who do not trust the midwife, are likely to not trust the health care system either. Such trust is trust with eyes wide open to the reality of what is possible, including the possibility of disappointment (Solomon & Flores, 2001). It may be that the woman trusts the midwife to keep her safe through her birthing, even if she has little confidence in her as a person.

The tensions that midwives in this study described were similar to those found by Garratt (2014) amidst independent midwives in the United Kingdom, namely, the potential to blur work-life boundaries and the focus on supporting the woman's choice. Managing boundaries to ensure they care for themselves is part of learning to work as a caseloading midwife. The consequences for getting it wrong may lead to a loss of joy in the role, or perhaps burnout (Young, 2011). Like midwives in Garratt's (2014) study midwives in this study also shared stories of when supporting the woman left them feeling their colleagues did not agree with their decision. It seems there is a depth to the decisions that midwives and women make that are not readily understood by those outside of the relationship. It is little wonder then that midwives in this study reported documenting such decisions clearly, so they had a record of their decision making in the event of an adverse outcome.

It seems that navigating being professional and being with the woman takes practice. This study showed how the midwives learned over time how to manage professional boundaries

while ensuring a relationship that worked. This reflects Sharpe's (2004) study into the midwife-woman relationship in Ontario, Canada. It is suggested that in getting close within the professional relationship there is a risk that midwives lose sight of their professional responsibilities, or that their decision making becomes flawed (Midwifery Council, 2010). Sharpe (2004) observed that in pursing professional status midwives in Canada had lost something in the way they worked with women. As well, Smythe, Hennessy, Abbott and Hughes (2017) found that mental health support workers seemed freer to grow a stronger relationship without 'professional' boundaries being in place and wondered if professional boundaries limited trust. The midwives in this study balanced being with the woman with maintaining professional boundaries. It seems that while having clear perimeters there was some flexibility that supported the relationship. Learning to work with such flexibility took practice.

Reviewing my understandings

I came to this study with an understanding that the midwife-woman relationship was important. I found myself in awe of the stories participants shared which showed how midwives worked with women to build a trusting relationship. But I as I listened to the stories where the relationship had not gone well, where trust was low, I wondered what had gone wrong. I have come to understand that what makes the midwife-woman relationship 'right' is complex. While it entails a set of skills and attributes, it is also about coming to trust each other. Such trust can be described as a feeling, often lingering although it may be fleeting, or perhaps something that is only known in hindsight. I have greater awareness of the importance of conversation to maintain a shared understanding and how that contributes to trust that is authentic. These are conversations that are not just chatting, although that may set the mood for a deeper conversation, but a conversation that sets out to plan together for the journey ahead.

My deepening understanding of trust has given me new respect for something that I suspect I often took for granted. Reading about the possibility of confusing familiarity with trust made me wonder how often I had done just that. How often had I assumed? Yet the stories in this study and my own experience suggest that midwives are skilled at interpreting what the woman is saying and reading between the lines. But failing to check if our assumptions are correct carries a risk of getting it wrong. In my care of women I now find myself checking in more often, asking about their concerns, their hopes and dreams. Sometimes a response surprises me and I wonder what might have happened had I not known of what was

concerning to her. I have also come to appreciate that there is something powerful in the relationship when the midwife accepts the woman for herself. Yet such relationships often call on great courage from the midwife to work with women who perhaps resist a relationship in the way that makes care easy. It seems to be that becoming a midwife takes more than book smarts since there is much to be learned on the job. I now discuss my recommendations for practice, education and further research.

Recommendations for practice

On the face of it, having a choice of midwife gave the woman the opportunity to find someone who fitted with her worldview. Yet this brought its own challenges. How does the woman find that midwife? Word of mouth provided recommendations that the women often trusted. Others had looked at the *Find your midwife* website for options. However, not all online profiles revealed enough about the midwife as a person or her philosophy that the women felt confident they would be a fit. I wonder whether video recorded information from the midwife could help women at this time.

Some midwives offered a 'meet and greet' option where women could meet with them, whereas others used the first meeting to book the woman under their care. This meant that if the midwife was not 'right' it was now harder for the woman to tell her no. There is currently no funding for a meet and greet option. If the woman and midwife's expectations are aligned they are likely to experience the positive relationship which both seek. This may be a conversation the profession should advance.

From this study it seems that women do not have a good understanding of the range of midwifery practice. Nor I argue, do many politicians and hospital managers. I am aware of information on websites such as the College of Midwives, Midwifery Council and Ministry of Health. Some of these include suggestions for questions to ask the midwife which relate to her caseload and philosophy of care, for example, her care if the woman has a long labour or requires an epidural. Perhaps a 'day in the life of the midwife' type of clip (something like 'my Māori midwife' which screens on television) could increase understanding.

It seems that some midwives did not recognise the vulnerability of the woman when she contacted them. Women described midwives who were abrupt or who did not want to meet

with them too soon. Perhaps the midwife was busy at that time. I recommend that midwives provide women with clear guidance about times and days that are appropriate to contact them, for example between 9 and 5pm Monday to Friday if that is what they prefer. While some midwives include similar information on their *Find your midwife* profile, others do not. When the midwife demonstrates kindness and empathy it reflects on the profession as a whole, and this is likely to pave the way for the woman's journey.

Midwives are encouraged to manage expectations and be explicit about their role, including how they choose to work in secondary settings. It seems that some women have been surprised by the midwife leaving them during long or complex labours and births.

Recommendations for education

This study has revealed the skills midwives use to build and maintain trusting relationships. Part of this may include managing difficult conversations. Such skills are relevant for both students and midwives to hone their abilities to respond to the variety of situations they experience.

The close relationship can challenge understandings of professional boundaries. From this study it seems that boundaries are best understood by increasing the midwives' awareness in such situations, rather than through guidelines or frameworks. Therefore, I suggest that midwives engage with scenarios that test professional boundaries to share their experiences when working with ethical issues and enhance their skills to manage such situations. While boundary work is also included in the undergraduate programme, this is something that takes time to learn to manage. Currently mentors are encouraged to support new graduate midwives to manage these in real time as they navigate their first year of practice.

The notion of trust is complex. Education to increase understanding of how trust supports the relationship and ways to establish trust (while remembering that trust must also be given), may support midwives in their work. This could also include education to increase awareness of the impact of vicarious trauma on the midwife and strategies to help midwives manage this. As well, strategies to support midwives when the relationship is difficult would be helpful, for example when the woman is not engaged in a relationship. Midwives have

significant experience in managing these and their learning would be beneficial for their colleagues and students.

Recommendations for further research

This study heard the midwives' perspective of caring for women who were not engaged in the relationship. But I wonder what the woman's perspective would be. Of course the woman who does not engage in a relationship (or perhaps *that* relationship) may not wish to participate in a study but her story is important and contributes to our understanding of her experience. Such research may challenge the assumption that the woman is not interested. Further, the findings may contribute to understandings that help to reduce the inequities that are present amongst women who do not access antenatal care (PMMRC, 2021).

The perspective of core midwives in Aotearoa New Zealand and their relationships with women should be explored. However, I acknowledge this is from a different perspective to that of the caseloading midwife. I wonder whether the experience of their relationship is enhanced because the woman knows and trusts the abilities of her known midwife and whether this extends to include the core midwife.

This study did not set out to hear from a group of ethnically diverse women. However, the voice of Māori women has not been identified. Further, it has been suggested that the partnership model is for "white, articulate, educated, middle-class women" (Skinner, 1999, p. 14). The Perinatal and Maternal Mortality Review Committee report shows increased mortality and morbidity for women and their babies who are Māori, Pacific or Indian (PMMRC, 2021). It may be that partnership is not working well for all women. A review of the experiences of Māori in the public health system showed that Māori are not well served by existing health structures (Graham & Masters-Awatere, 2020). Further research to understand how the relationship is experienced by Māori and Pacific women and midwives would be beneficial to explore ways to reduce inequalities in birth outcomes for these groups of women.

The midwives in this study described how they carefully documented their care and decisions when the woman was not engaged in care or did not enact their advice. I wonder if midwives feel responsible when the woman does not engage in care or follow her advice? I

wonder if the GP has the same concerns, or the hospital doctor. Such concerns do not reflect the concept of partnership. An exploration of this area of practice would be useful to help understanding of the professional responsibilities at play.

This study did not seek to understand midwives decision making within a close relationship. However, the literature review raised a possible concern about any impact. Midwives in this study described making decisions in partnership with women. To me this sounds like the process of informed decision making as described by the Code of Rights (HDC, 1996). A possible area of further study would be to understand the ways that emotional connection with the woman influences the midwife's decision making and their understanding of professional responsibilities.

Study limitations

The hermeneutic approach seeks to reveal understanding that lie hidden. As such, understanding is always continuing to unfold. This study seeks to add to our understanding of midwifery professional relationships, while knowing there is more that remains still to be revealed. This study focused on participants from the upper North Island who represented a range of locations and experiences. However, the voice of a wider range of participants would increase our understanding of the professional relationship. The participants self-selected and were not intended to be representative of all midwives and women who have experienced caseloading midwifery in Aotearoa New Zealand. It seemed that all participants preferred a close relationship, however not all had experienced this in each relationship. No midwife or woman in this study had lodged a formal complaint against the other person in the relationship although such stories may have added to the analysis.

When undertaking the interviews, I noticed that the midwives talked for longer, indicating they had more stories to tell. They also had a broader range of experiences. The women described mostly positive relationships although some had experienced difficult relationships. Consequently, within this thesis I have used more quotes from the midwives than the women. The interpretation of the participant's stories is mine and reflects my understanding of what was meant. While I have examined this closely and discussed my findings with my supervisors, the interpretation is just one of many that may be possible. I acknowledge that over time, other possibilities may surface that I am not yet attuned to, and that this is the nature of hermeneutic phenomenology. Perhaps this conundrum is best

summed up by van Manen (1997) who suggests that doing "hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal" (p. 18).

Concluding thoughts

Relationships are tricky at the best of times. However, much is at stake for the woman since how the relationship plays out flavours her birth experience and is remembered for a long time. While the midwife can walk away at any time, the woman must give birth. The women and midwives in this study sought a close relationship, but the reality is that this did not always occur. Some relationships become very close with high levels of trust and mutual respect, while others limped along, dogged by mistrust and disappointment. Understanding was always being renewed through conversation and it was through understanding that trust was built. Like the cabinet maker who responds to the different kinds of wood to reveal the "hidden riches of its essence" (Heidegger, 1997, p. 379), the midwife needs to attune to the possibilities that each woman brings and work with her to achieve her goals. Trusting relationships gave both the woman and midwife confidence to journey toward the unknown that birth was. Within some trusting relationships, women experienced the pregnancy journey as profound. Other relationships came to trust in a fashion that reflected what trust the woman was prepared to give. In such relationships it may be that both come to trust the other to do what is needed at the time, and little else.

So how do caseloading midwives and the women for whom they care understand the professional relationship? The frameworks and expectations that both bring shape how the relationship is understood. As they engage in conversation, they develop a shared understanding of how the relationship and the pregnancy journey may play out. Talking sets out to reveal previous understandings and prejudices, some of which the woman, and perhaps the midwife, may not be aware of. In the back and forth of conversation understanding is increased toward a fusion of horizons (Gadamer, 2013). In turn, this supports the development of trust that is authentic, that is, trust with eyes wide open. Odent (2002) argues that this is what the woman needs to feel secure so that she can get on with the business of birthing knowing she is safe. In relationships where conversation is limited, the relationship is likely to experience low trust. However, this may be trust that is focused on keeping the woman safe through her birthing journey, and that is better than nothing.

Relationships are dynamic and so are always on the way. They can be messy or difficult and require ongoing work to ensure understanding is shared. In this study stories were shared where the midwife was not present in the relationship, perhaps because she was too busy or weary, and of women who did not understand or perhaps respect the professional life of the midwife. If midwives are to provide continuity of care to all women, including those who do not seek a trusting relationship, then they need the courage and skills to manage uncomfortable conversations and to challenge difficult behaviour. A trusting relationship contributes to care that is safe. As well, it is a trusting relationship that provides some certainty amidst the unknown of the pregnancy journey. Gadamer (2013) suggests that thinking is never done because understanding is always on the way. There is still more thinking to be done on how midwives can nurture, protect and uphold trust amidst the complex nature of their lives. Perhaps that is the fresh challenge that comes with every midwife-woman relationship, from both sides. This thesis simply reminds us anew that trust matters.

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Appendices

Appendix A: AUTEC Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

5 August 2016

Elizabeth Smythe
Faculty of Health and Environmental Sciences

Dear Elizabeth

Re Ethics Application: **16/268 An exploration of the professional relationship between caseload midwives and the women they care for.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 4 August 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 4 August 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 4 August 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Liz James; lizjames@clear.net.nz; Deb Payne; Carolyn Young

Appendix B: Participant Information Sheet - Women

Participant Information Sheet for women participants

Date Information Sheet Produced: 22 June 2016

Project Title

An exploration of the professional relationship between caseloading midwives and the women they care for

An Invitation

Kia ora - my name is Liz James. I am the Team Manager for the Bachelor of Midwifery programme at Wintec. Previously, I have worked as a LMC midwife in the community for many years. I would like to invite you to participate in this study. This research is conducted as a requirement for a PhD. Your decision to participate is voluntary and you may withdraw at any time prior to the completion of data collection. Whether you choose to participate or not will neither advantage nor disadvantage you.

What is the purpose of this research?

Within the course of my work as an educator I became interested in how midwives understand and work within the midwife-women relationship. Studies show that the quality of the midwife-woman relationship influences the outcome for the woman, and job satisfaction for the midwife. I am interested in how women decide if the professional relationship is both supportive and efficient. I plan to interview midwives who have worked as a caseloading/LMC midwife, and women who have accessed midwifery care within the last three years. It is hoped the research will increase understanding of how midwives manage professional relationships with the women in their caseload. The results from this study may be used in academic publications and presentations. An electronic copy of the thesis will become widely available, as the Auckland University of Technology requires that a digital copy of Doctoral theses be lodged permanently in the University's digital repository.

How was I identified and why am I being invited to participate in this research?

You have responded to a flyer as a woman who has experienced LMC midwifery care within the last three years and may be interested in participating.

What will happen in this research?

If you agree to participate in this research I will negotiate a time and place for an interview lasting approximately one hour. The interview will be a conversational style with open questions about your experiences of your professional relationship with a caseloading midwife. The interview will be audio recorded and later transcribed for my analysis. The transcript will be crafted into stories and sent to you for you to review and any corrections or clarification will be welcomed. Before we start the interview you will have the opportunity to ask questions prior to signing the consent form.

What are the discomforts and risks?

I do not anticipate any discomforts or risks to you by participating in this study. However, I acknowledge that sometimes when reviewing experiences you may identify issues that cause you discomfort. I anticipate that mostly you will enjoy reflecting on your previous relationship.

How will these discomforts and risks be alleviated?

In the event of any discomfort related to your birth experience, you can provide feedback via the New Zealand College of Midwives feedback and resolutions service or through the Health and Disability Commissioner. Additionally, you may access AUT counselling services, should you feel you feel the research process has been harmful. AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into their centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992

• let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

By being involved in the interview you are likely to contribute to increased understanding of the midwife-woman relationship and have a higher awareness of professional relationships.

How will my privacy be protected?

The audio tapes and transcripts will remain confidential to myself, the transcriber and my supervisors. The transcriber will sign a confidentiality agreement. The recordings and transcripts will be held in a secure location and treated with the strictest confidentiality. They will be destroyed six years following completion of the PhD degree. No participants will be named in the publications and every effort will be made to disguise your identity. While every effort will be made to ensure confidentiality, including anonymity, this cannot be guaranteed. I will change your name to a pseudonym in my thesis and change any details that could identify you. You will also be provided with your crafted story to review and may delete or change any parts that you feel you want left out of the study.

What are the costs of participating in this research?

It is anticipated that you will give approximately 1 hour of your time for the interview and 1 hour to review your stories. Additionally, you will be provided with petrol vouchers at the end of the interview to contribute to travel and parking costs.

What opportunity do I have to consider this invitation?

Once you have read this invitation please contact me within two weeks if you wish to clarify any points or if you wish to participate. I will not contact you.

How do I agree to participate in this research?

If you agree to participate I will negotiate a date, time and venue with you for the interview. At the start of the interview I will provide you with a consent form to read, sign and date. You will be able to ask questions before signing the consent form. If you take part in the research, you have the right to:

• Chose not to answer any particular question
• Withdraw from the research at any time before confirmation of your crafted story.
• Ask any questions about the research that occur to you during your participation.
• Be given access to a summary of the findings from the research when it is concluded.

Will I receive feedback on the results of this research?

If you would like a summary of the final report this will be sent to you once the thesis is completed.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Liz Smythe, liz.smythe@aut.ac.nz , 09 921 9999 ext 7196

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 09 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Liz James, lizjames@clear.net.nz, 021 829 959

Project Supervisor Contact Details:

Dr Liz Smythe, liz.smythe@aut.ac.nz , 09 921 9999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on *5 August 2016*, AUTEC Reference number *16/268*.

Appendix C: Participant Information Sheet - Midwives

Participant Information Sheet for midwife participants

Date Information Sheet Produced: 22 June 2016

Project Title

An exploration of the professional relationship between caseloading midwives and the women they care for

An Invitation

Kia ora - my name is Liz James. I am the Team Manager for the Bachelor of Midwifery programme at Wintec. Previously I have worked as a LMC midwife in the community for many years. I would like to invite you to participate in this study. This research is conducted as a requirement for a PhD. Your decision to participate is voluntary and you may withdraw at any time prior to the completion of data collection. Whether you choose to participate or not will neither advantage nor disadvantage you.

What is the purpose of this research?

Within the course of my work as an educator I became interested in how midwives understand and work within the midwife-woman relationship. Studies show that the quality of the midwife-woman relationship influences the outcome for the woman, and job satisfaction for the midwife. Additionally, there is a tension between the relational aspects of midwifery, and the concepts of professionalism and efficiency. I plan to interview midwives who have worked as a caseloading midwife, and women who have accessed midwifery care within the last three years. It is hoped the research will increase understanding of how midwives manage professional relationships with the women in their caseload. The results from this study may be used in academic publications and presentations. An electronic copy of the thesis will become widely available, as the Auckland University of Technology requires that a digital copy of Doctoral theses be lodged permanently in the University's digital repository.

How was I identified and why am I being invited to participate in this research?

You have responded to an email or flyer as a community based midwife who has worked in LMC practice and may be interested in participating.

What will happen in this research?

If you agree to participate in this research I will negotiate a time and place for an interview lasting approximately one hour. The interview will be a conversational style with open questions about your experiences of professional relationships. I am interested in how you navigate the situations that arise, and what supports you to do this. The interview will be audio recorded and later transcribed for my analysis. The transcript will be crafted into stories which will be sent to you for you to review and any corrections or clarification will be welcomed. Before we start the interview you will have the opportunity to ask questions prior to signing the consent form.

What are the discomforts and risks?

I do not anticipate any discomforts or risks to you by participating in this study. However, I acknowledge that sometimes when reviewing experiences you may identify issues that cause you discomfort. In the event of any discomfort that may arise from the interview process, you can access EAP or AUT counselling services. AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into their centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

By being involved in the interview you are likely to have a higher awareness of professional relationships and this is arguably positive. You will also have contributed to research that seeks to learn more about the midwife-woman relationship.

How will my privacy be protected?

The audio tapes and transcripts will remain confidential to myself, the transcriber and my supervisors. The transcriber will sign a confidentiality agreement. The recordings and transcripts will be held in a secure location and treated with the strictest confidentiality. They will be destroyed five years following completion of the PhD degree. No participants will be named in the publications and every effort will be made to disguise your identity. While every effort will be made to ensure confidentiality, including anonymity, this cannot be guaranteed. I will change your name to a pseudonym in my thesis and change any details that could identify you. You will also be provided with your crafted story to review and may delete or change any parts that you feel you want left out of the study.

What are the costs of participating in this research?

It is anticipated that you will give approximately 1 hour of your time for the interview and 1 hour to review your story. Additionally, you will be provided with petrol vouchers at the end of the interview to contribute to any travel and parking costs.

What opportunity do I have to consider this invitation?

Once you have read this invitation please contact me if you wish to clarify any points or if you wish to participate within two weeks. I will not contact you.

How do I agree to participate in this research?

If you agree to participate I will negotiate a date, time and venue with you for the interview. At the start of the interview I will provide you with a consent form to read, sign and date. You will be able to ask questions before signing the consent form. If you take part in the research, you have the right to:

- Chose not to answer any particular question
- Withdraw from the research any time before confirmation of your crafted story.
- Ask any questions about the research that occur to you during your participation.
- Be given access to a summary of the findings from the research when it is concluded.

Will I receive feedback on the results of this research?

If you would like a summary of the final report this will be sent to you once the thesis is completed.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Liz Smythe, liz.smythe@aut.ac.nz , 09 921 9999 ext 7196

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 09 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Liz James, lizjames@clear.net.nz, 021 829 959

Project Supervisor Contact Details:

Dr Liz Smythe, liz.smythe@aut.ac.nz , 09 921 9999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on *5 August 2016*, AUTEC Reference number *16/268*.

Appendix D: Participant Consent Form

Consent Form

Project title: An exploration of the professional relationship between caseloading/LMC midwives and the women they care for

Project Supervisor: *Dr Liz Smythe*

Researcher: *Liz James*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 22 June 2016.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: ....

Participant's name: ....

Participant's contact details to send research findings (if appropriate):

………………………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on *5 August 2016*, AUTEC Reference number *16/268*.

Note: The Participant should retain a copy of this form.

Appendix E: Researcher Safety Protocol

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Researcher's safety protocol

Project title: An exploration of the professional relationship between caseloading midwives and the women they care for

I do not anticipate any risks but outline the following arrangements for my safety when undertaking interviews for this study:

- When undertaking interviews in private homes and/or community based meeting areas, I will inform a colleague of my travel plans and interview schedule for that day.
- The colleague will be given the date, time and address of the interview and advised of their action should they not receive notification that the interview is completed.
- I will text the colleague prior to commencing the interview to confirm my actions and timelines.
- If the colleague does not receive any notification after the interview they will try and contact the researcher by phone in the first instance. If there is no response within 15 minutes the colleague will try to call again and then escalate a potential at risk situation and notify the police of the details.
- Interviews will not occur in the researcher's own home.
- When visiting participant's in their homes, I am mindful that I need to act in culturally and socially sensitive ways, remembering I am a guest.
- I acknowledge that it is the participants who are doing me the favour by agreeing to participate and share their experiences.

Appendix F: Conversation Prompts/Questions

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Indicative questions

Project title: An exploration of the professional relationship between caseloading midwives and the women they care for

These questions act as prompts for a conversational style of interviewing. Not all will necessarily be used in each interview.

Questions for midwives

- Can you tell me what you look for in a relationship when first meeting a woman?
- Tell me about a relationship with a woman you cared for that stands out in your mind
- Do you remember a time when a woman pushed you beyond your sense of what was right (boundaries)?
- Can you tell me about a time when a woman's behaviour challenged you?
- Can you tell me about a relationship that went well?
- Do you remember a particularly close relationship with a woman, maybe where you would have liked her as a best friend?
- Can you tell me about any relationships you would have liked to have ended?

Questions for women

- Tell me about how you choose your midwife? What were you looking for?
- Tell me about a part of your relationship with a midwife that stands out in your mind
- All relationships have expectations and understandings about how you interact together. Can you tell me about your expectations of your relationship with the midwife?
- Tell me about what was important for you within the relationship with the midwife
- Can you tell me about any times where you felt uncomfortable or uncertain in your relationship with the midwife?
- Can you tell me about what makes a midwife relationship good?
- Can you tell me about how the relationship ended?

Appendix G: Transcriptionist Confidentiality Form

Confidentiality Agreement

Project title: An exploration of the professional relationship between caseloading midwives and the women they care for

Project Supervisor: *Dr Liz Smythe*

Researcher: *Liz James*

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ....

Transcriber's name: ....

Transcriber's Contact Details:

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Date:

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Approved by the Auckland University of Technology Ethics Committee on 5 August 2016, AUTEC Reference number 16/268.

Note: The Transcriber should retain a copy of this form.

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Appendix H: Example of Crafting a Story

Example of transcript to crafted story

Transcript

Liz - So just thinking about um, when midwife was providing care for you, did you feel able to contact her to ask her questions?

Ruth - Um yeah definitely. I was um it took me awhile to kind of get the grasp on when to text or when to call. And she was quite specific about that. So sometimes I was a little bit um, probably hesitant to call her um and I'd just text and, and she always got back to me so that was really good. Um but just trying to, because that was all new to me so I was trying to figure out when, when I could call her knowing that she had other um, ladies she was looking after and that, or if she was in a birth I didn't want to bother her and things. So yeah I definitely felt like I could contact her. It was just um trying to figure out that way of how to and what was appropriate for my questions.

To crafted story

My midwife was specific about when to contact her and it took me a while to grasp when to text or when to call. Sometimes I was a little hesitant to call her so I'd just text. She always got back to me which was good. I was trying to figure out when I could call her knowing that she had other ladies she was looking after, or if she was in a birth I didn't want to bother her. I felt I could contact her, it was just trying to figure out what was appropriate (Ruth, woman).

Appendix I: Table showing each theme with the titles beneath

findings chapters							
5		6		7		8	
Initiating the relationship		***Working with boundaries***		***When tension arises***		***Relationship goes well***	
Finding the midwife		**Setting boundaries**		**Different expectations**		**Trust**	
no idea what to do	Ruth	being explicit	Deb mw	mw didn't know	Judy mw	begins with hearing	Jane
what to look for?	Maisie	woman trying to figure it out	Ruth	she didn't know	Amy	finding things in common	Maisie
looking for right one	Jo	struggling setting boundaries	Clare mw	distance in relationship	Judy mw	opens up the issues	Clare mw
looking for right fit	Ruth	protects boundaries	Kelly mw	she didn't care	Serena	does not rush	Milly
		not about the mw	Rose mw	expectation from prev mw	Deb mw	trust transferable	Stella
		woman's perspective	Milly	too familiar	Kiera	felt cared for	Ruth
						trust enables woman to grow	Milly
Expectations		**Maintaining boundaries**		**Crossed boundaries**		**Being trustworthy**	
mw lays out limits	Kelly mw	reiterating	Clare mw	always excuses	Judy mw	mw keeping woman safe	Stella
feeling a connection	Jane	too many calls	Heather mw	frustrated with behaviour	Annie mw	mw respect for woman	Rose mw
mw looks for connection	Kelly mw	texts	Carol mw	feeling unsafe	Kelly mw	trusted by family	Deb mw
mw experience matters	Jane	mw sets boundaries	Deb mw	don't know what is happening	Clare mw	trust is a thin line	Carol mw
feeling cared for matters	Stella	woman sets boundaries	Jo	in complex situation	Rose mw	mw learns to trust woman	Judy mw
listening matters	Milly	boundaries tested	Annie mw	struggling with life choices	Carol mw	trust after stillbirth	Annie mw
feeling safe matters	Amy	flexing boundaries	Rose mw	saying no	Heather mw	strong bond	Jo
need her focused on me	Ruth	mw boundaries too open	Kiera			trust in hindsight	Serena
mw looks for relationship	Judy mw	consequence of no boundaries	Heather mw				
Making the commitment		**When boundaries get blurred**		**Working with tensions**		**Ending the relationship**	
urgent decision	Jane	know a lot	Heather mw	mw does not feel trusted	Kelly mw	lost a vital person	Maisie
judgement	Stella	need to respect mw	Jane	struggling with personalities	Deb mw	mw draws back	Judy mw
feels like it will work	Maisie	asked to be godmother	Heather mw	mw out of her depth	Clare mw	seeing each other after	Annie mw
not easy to say no	Maisie	care to friends	Deb mw	keeping baby safe	Rose mw		
		deciding not to care for friends	Annie mw	keeping woman safe	Kelly mw		
				woman makes decision	Deb mw		
				one thing	Jane		
				trust in flux	Jo		